

Complete all sections and check all box(es) that apply. Return completed form to your Human Resources Department.

MEMBER INFORMATION

Your Name (Last, First, Middle)	Soc. Sec. No.	
Group Name	Group Number	Division ID

TERMINATION

Please terminate my contributory group insurance coverage on the last day of / . **Please do not deduct any further premiums that would extend the discontinued group insurance coverage beyond that date.**
Month Year

Life Life/AD&D Additional Life Supplemental Life
 Dependents Life: Spouse Dependents Life: Children
 AD&D AD&D Dependents: Spouse AD&D Dependents: Children
 Short Term Disability Enhanced Short Term Disability
 Long Term Disability-Cancel Enhanced Long Term Disability
 Dental Dental High Plan

REDUCTION

Please reduce the amount of my contributory group insurance coverage as indicated.

Life Insurance Life Additional Life
 New requested amount _____ Life/AD&D Supplemental Life

Dependents Life Insurance
 Spouse new requested amount _____ Children new requested amount _____

Accidental Death and Dismemberment (AD&D) Insurance
 New requested amount _____ Spouse new requested amount _____
 Children new requested amount _____

Disability Insurance
 Short Term Disability New Plan _____ Long Term Disability New Plan _____

Dental Insurance
 Dental New Plan _____

SIGNATURE

I wish to reduce or terminate my group insurance coverage as noted above. I understand that I may be required to provide Evidence Of Insurability at my own expense to increase coverage or become insured again and that Standard Insurance Company will have the right to refuse my request. I understand that if I become insured again additional restrictions and limitations may apply.

Member Signature Required	Date (Mo/Day/Yr)
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