INSURANCE CANCELLATION FORM

Date:

To Whom It May Concern:

I _____ I would like to
Name **Policy Number or Social Security Number**

stop deductions of the following insurance coverage with _____as of _____.
(Company) **(cancellation date)**

- o Basic Life
- o Optional Life (Plan B)
- o Cancer Insurance
- o Accident Insurance
- o Critical Illness Insurance
- o Universal/Whole Life Insurance
- o Short Term Disability (STD)
- o Long Term Disability (LTD)
- o Dental
- o Vision

X

_____
Signature

_____
Print Name

_____
Municipality/Company

For Office Use Only

Date **Initials**
_____Ins. Carrier
_____Payroll Contact

Fax completed form to **LifePlus Insurance Agency** for processing: **781-837-9227**
Or Mail to: LifePlus Insurance Agency, 475 School Street, Ste. 5, Marshfield, MA 02050