Reset

Standard Insurance Company

Termination or Reduction of Contributory Group Insurance

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 Buy Up
- ☐ Enhanced Long Term Disability
- ☐ Dental
- ☐ Dental High Plan

REDUCTION

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

Life Insurance

New requested amount _____

- ☐ Life
- ☐ Life/AD&D
- ☐ Additional Life
- ☐ 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)

Human Resources Department – Retain for your records.