RETIREE LIFE CANCELLATION FORM

Please use this form if you would like to cancel your coverage on the Retiree Life Insurance Plan offered by the UCM Benefits Group. NOTE: Once coverage is cancelled you can not return to plan.

SECTION 1: Participant Identification

Participant Name: ______________________________________

Participant SSN: _______________________

Address: ____

City: _______________________________ State: _____________ Zip: __________

Home Phone: _______________________

SECTION 2: Termination Information

Termination Effective Date is December 31, _____________

SECTION 3: Signature

I hereby certify, by my signature, that in accordance with the UCM Plan, if a retiree terminates participation in the Life Insurance Plan, such covered persons may not become a covered person there after.

Print Name: ___________________Signature: ____________________Date: _________

BY MAIL:
Office of Human Resources
Benefits
101 Administration Bldg
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