

*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  
 Short Term Disability               Enhanced Short Term Disability  
 Long Term Disability               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 \_\_\_\_\_

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 The Standard Life Insurance Company of New York 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.*