



## **Supplemental Voluntary Life Insurance Cancellation Request**

**Printed Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Insurance Carrier Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

I am requesting to cancel my Voluntary Life Insurance that I am currently enrolled in with CMCSS. I understand that if I would like to participate in the future, I would be required to provide evidence of insurability which may require a physical. Furthermore, I understand that my request may be denied by the insurance provider.

Your request for cancellation will go into effect the beginning of the next month. A minimum of ten (10) days notice is required.

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**Employees Signature**

**Please return this request to the Benefits Office.**