

Warrensburg, MO 64093

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 Ident	ification	
Participant Name:		
Participant SSN:		
Address:		
City:	State:	Zip:
Home Phone:		
SECTION 2: Termination Info	rmation	
Termination Effective Date is De	ecember 31,	
SECTION 3: Signature		
, , , , ,	e, that in accordance with the UCI fe Insurance Plan, such covered	· · · · · · · · · · · · · · · · · · ·
Print Name:	Signature:	Date:
BY MAIL: Office of Human Resources Benefits 101 Administration Bldg	BY FAX: 660-543-4200	