NOTICE OF
Cancellation/Termination/Leave of Absence/Direct Bill Request

P.O. Box 1237
Glastonbury, CT 06033
(800) 229-5129
FAX (860) 659-5921

Employee Name	Employer Name
Current Street Address	Home Phone
City State Zip	Employee Email
Employee I.D. or Social Security No.	

I hereby notify my employer that effective ____/____/_____, I request the following change in my worksite benefit plan(s):

CHECK APPROPRIATE ITEM(S)

VOLUNTARY LIFE PROGRAM

Policy # _____

- ☐ I am terminating my employment and wish to continue my coverage
- ☐ Cancel my payroll deduction and coverage and surrender all policy(ies) and forward policy reserves to my home address
- ☐ Other _____

DISABILITY INSURANCE BENEFIT PROGRAM

Short Term Policy # _____

Long Term Policy # _____

- ☐ I am terminating my employment and wish to continue my coverage
- ☐ Cancel my payroll deduction and coverage
- ☐ Other _____

ACCIDENT PROGRAM

Policy # _____

- ☐ I am terminating my employment and wish to continue my coverage
- ☐ Cancel my payroll deduction and coverage
- ☐ Other _____

CRITICAL ILLNESS/CANCER

Policy # _____

- ☐ I am terminating my employment and wish to continue my coverage
- ☐ Cancel my payroll deduction and coverage
- ☐ Other _____

OTHER VOLUNTARY BENEFIT PROGRAM (S)

Benefit: _____

Policy # _____

- ☐ I am terminating my employment and wish to continue my coverage
- ☐ Cancel my payroll deduction and coverage
- ☐ Other_____

COMMENTS/INSTRUCTIONS

_____

_____

_____

_____

_____ _____

Employee Name (Signature) Date

PLEASE MAIL THE ORIGINAL - WHITE COPY - IMMEDIATELY TO EMPLOYEE FAMILY PROTECTION, INC.

White Copy - Original **Yellow Copy - Payroll/Personnel** **Pink Copy - Employee**