

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 Merrill Area Public Schools	Group Number 163288	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

<p>Life Insurance</p> <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary Life with AD&D <input type="checkbox"/> Additional Life <input type="checkbox"/> Additional Life with AD&D <input type="checkbox"/> Supplemental Life	<p>Dependents Life Insurance</p> <input type="checkbox"/> Basic Spouse Life / Child Life <input type="checkbox"/> Spouse Life <input type="checkbox"/> Spouse Life with AD&D <input type="checkbox"/> Child Life <input type="checkbox"/> Child Life with AD&D	<p>Disability Insurance</p> <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Buy-up Short Term Disability <input type="checkbox"/> Buy-up Long Term Disability <input type="checkbox"/> Educator Options/Your Choice
<p>Accidental Death and Dismemberment (AD&D) Insurance</p> <input type="checkbox"/> Voluntary AD&D (Employee Only) <input type="checkbox"/> Voluntary AD&D (Spouse Only) <input type="checkbox"/> Voluntary AD&D (Child Only) <input type="checkbox"/> Voluntary AD&D (Employee plus Family)	<p>Supplemental Insurance</p> <input type="checkbox"/> Accident <input type="checkbox"/> Accident (Spouse Only) <input type="checkbox"/> Accident (Child Only) <input type="checkbox"/> Hospital Indemnity <input type="checkbox"/> Hospital Indemnity (Spouse Only) <input type="checkbox"/> Hospital Indemnity (Child Only)	<p>Dental / Vision Insurance</p> <input type="checkbox"/> Critical Illness <input type="checkbox"/> Critical Illness (Spouse Only) <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> PolicyLink (Dental & Vision)

REDUCTION

Please reduce the amount of my contributory group insurance coverage as indicated.

<p>Life Insurance</p> <p>Employee new requested amount \$ _____</p>	<input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary Life with AD&D <input type="checkbox"/> Additional Life with AD&D	<input type="checkbox"/> Additional Life <input type="checkbox"/> Supplemental Life
<p>Dependents Life Insurance</p> <input type="checkbox"/> Spouse new requested amount \$ _____	<input type="checkbox"/> Child new requested amount \$ _____	
<p>Accidental Death and Dismemberment (AD&D) Insurance</p> <input type="checkbox"/> Employee new requested amount \$ _____	<input type="checkbox"/> Spouse new requested amount \$ _____ <input type="checkbox"/> Child new requested amount \$ _____	
<p>Disability Insurance</p> <input type="checkbox"/> Educator Options/Your Choice new requested amount \$ _____		
<p>Supplemental Insurance (Critical Illness)</p> <input type="checkbox"/> Employee new requested amount \$ _____	<input type="checkbox"/> Spouse new requested amount \$ _____	
<p>Dental / Vision Insurance</p> <input type="checkbox"/> Dental new plan _____	<input type="checkbox"/> Vision 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 Standard Insurance Company 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)
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