For Benefits Staff Use Only
VTL Cancellation or Reduction
Effective Date:
____/____/____

Voluntary Term Life Insurance

CANCELLATION OR REDUCTION REQUEST FORM

Employee Name (please print): _____

Employee #: _____

Department & Division: _____

Work # or Daytime Phone: _____

Please cancel or reduce the following Voluntary Term Life Policy(s) effective as of: _____ 01, 20___

Employee's Policy: ☐ Cancel or ☐ New Benefit Amount: $ _____
Spouse's Policy: ☐ Cancel or ☐ New Benefit Amount: $ _____
Child(ren)'s Policy: ☐ Cancel or ☐ New Benefit Amount: $ _____

> Cancelling employee policy will automatically cancel spouse or child(ren) coverage.
> Amount for spouse must be equal to or LESS than employee's coverage.
> Coverage for employee and spouse must be in $10,000 increments.
> This form may NOT be used to INCREASE coverage.

Please Note: Cancellation or reduction requests are made for the first of the following month. In order for the change to occur, your form MUST be received by Employee Benefits at least two weeks prior to the first pay date of the month.

By signing this form, I authorize Marion County to cancel or reduce the above Voluntary Term Life Insurance Policy(s).

Employee Signature: _____ Date: _____

PLEASE MAKE A COPY FOR YOUR RECORDS BEFORE SENDING YOUR FORM TO EMPLOYEE BENEFITS.

Employee Benefits' Sign-Off: _____ Date: _____