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 in Business Services-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: _____