

# Cancellation Request



Insured's Name \_\_\_\_\_ Employee ID # \_\_\_\_\_  
Owner's Name \_\_\_\_\_ Owner's Social Security Number \_\_\_\_\_  
Owner's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP+4 \_\_\_\_\_  
Owner's Telephone \_\_\_\_\_

## Cancellation of Insurance

Reason for Cancellation \_\_\_\_\_  
\_\_\_\_\_

Policy Number(s) to Cancel \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I confirm that I wish to cancel the above listed policies.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Policyowner Date

Effective date of cancellation will be the first of the following month.  
Retroactive cancellations are not allowed.  
Scan and email completed cancellation form to County Benefits or fax to 567-4367 or 525-5779.