Reset

Standard Insurance Company

Termination or Reduction of Contributory Group Insurance

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. xxx-xx-	
Group Name **SWCD of Illinois Insurance Group Assoc**	Group Number **143112**	Division ID

TERMINATION

Please terminate my contributory group insurance coverage on the last day of _____ (Month) / _____ (Year). Please do not deduct any further premiums that would extend the discontinued group insurance coverage beyond that date.

Life Insurance
- ☐ Voluntary Life
- ☐ Voluntary Life with AD&D
- ☐ Additional Life
- ☐ Additional Life with AD&D
- ☐ Supplemental Life

Dependents Life Insurance
- ☐ Basic Spouse Life / Child Life
- ☐ Spouse Life
- ☐ Spouse Life with AD&D
- ☐ Child Life
- ☐ Child Life with AD&D

Disability Insurance
- ☐ Short Term Disability
- ☐ Long Term Disability
- ☐ Buy-up Short Term Disability
- ☐ Buy-up Long Term Disability
- ☐ Educator Options/Your Choice

Accidental Death and Dismemberment (AD&D) Insurance
- ☐ Voluntary AD&D (Employee Only)
- ☐ Voluntary AD&D (Spouse Only)
- ☐ Voluntary AD&D (Child Only)
- ☐ Voluntary AD&D (Employee plus Family)

Supplemental Insurance
- ☐ Accident
- ☐ Accident (Spouse Only)
- ☐ Accident (Child Only)
- ☐ Hospital Indemnity
- ☐ Hospital Indemnity (Spouse Only)
- ☐ Hospital Indemnity (Child Only)
- ☐ Critical Illness
- ☐ Critical Illness (Spouse Only)

Dental / Vision Insurance
- ☐ Dental
- ☐ Vision
- ☐ PolicyLink (Dental & Vision)

REDUCTION

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

Life Insurance

Employee new requested amount $ _____

- ☐ Voluntary Life
- ☐ Voluntary Life with AD&D
- ☐ Additional Life with AD&D
- ☐ Additional Life
- ☐ Supplemental Life

Dependents Life Insurance

- ☐ Spouse new requested amount $ _____
- ☐ Child new requested amount $ _____

Accidental Death and Dismemberment (AD&D) Insurance

- ☐ Employee new requested amount $ _____
- ☐ Spouse new requested amount $ _____
- ☐ Child new requested amount $ _____

Disability Insurance

- ☐ Educator Options/Your Choice new requested amount $ _____

Supplemental Insurance (Critical Illness)

- ☐ Employee new requested amount $ _____
- ☐ Spouse new requested amount $ _____

Dental / Vision Insurance

- ☐ Dental new plan _____
- ☐ 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)