RETIREE LIFE CANCELLATION FORM

Please use this form if you would like to cancel your coverage on the Retiree Life Insurance Plan offered by the UCM Benefits Group. NOTE: Once coverage is cancelled you can not return to plan.

SECTION 1: Participant Identification

Participant Name: _____

Participant SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

SECTION 2: Termination Information

Termination Effective Date is December 31, _____

SECTION 3: Signature

I hereby certify, by my signature, that in accordance with the UCM Plan, if a retiree terminates participation in the Life Insurance Plan, such covered persons may not become a covered person there after.

Print Name: _____Signature: _____ Date: _____

BY MAIL:
Office of Human Resources
Benefits
101 Administration Bldg
Warrensburg, MO 64093

BY FAX:
660-543-4200