INSURANCE CANCELLATION FORM

Date: _____

To Whom It May Concern:

I, _____ / _____
Name Policy Number or Social Security Number

I would like to cancel the following insurance coverage with _____.
(Insurance Company)

- o Basic Life
- o Optional Life (Plan B)
- o Cancer Insurance
- o Universal/Whole Life Insurance
- o Short Term Disability (STD)
- o Long Term Disability (LTD)
- o Dental

_____
Signature

_____
Print Name

_____
Municipality/Company

For Office Use Only

Date **Initials**
_____Ins. Carrier
_____Payroll Contact

Fax completed form to **LifePlus Insurance Agency** for processing: **781-837-9227**
Or Mail to: LifePlus Insurance Agency, 475 School Street, Ste. 5, Marshfield, MA 02050