Employee Benefit Drop Request
Of Current In-Force Coverage

Employer: _____

Employee: _____ **Last Four SSN/EEID:** _____

Please cancel my previously authorized benefit election(s) as follows. Please note if you are requesting a drop of your employer Major Medical or Association Major Medical coverage your employer may require additional paperwork.

Company	Benefit Type	Amount	Plan Effective Date

My signature below reflects my approval to cancel/drop the prior in-force coverage listed above. Coverage will remain in effect only until the Drop Effective Date listed.

Employee Name: _____
Signature: _____
Date of Transaction: _____