Voluntary Withdrawal of Supplemental Life Insurance

Employee Name: _____ Employee ID#: _____

I hereby request to terminate my voluntary supplemental life insurance coverage, including any spouse or dependent coverage that I may be enrolled in, effective _____.

I understand that I can only re-enroll in supplemental life insurance coverage during the next annual enrollment period, or with a Qualifying Life Event, and I may have to complete Evidence of Insurability and could be denied coverage by the Provider.

_____ _____

Employee Signature Date

Return completed form and return to the

Benefits Department

Fax (937) 496-7407

hr@mcohio.org