P.O. Box 349
Augusta, ME 04332-0349
Telephone: (207) 512-3100
Toll-free: 1-800-451-9800
Fax: (207) 512-3101
Maine Relay: 711

CANCELLATION/REDUCTION IN COVERAGE

Employee's Name: ______ (Prefix) ______ (First) ______ (MI) ______ (Last) ______ (Suffix)

Social Security Number: ______

Date of Birth: ______ (mm) ______ (dd) ______ (yyyy)

Mailing Address: ______ (Street/PO Box) ______ (City/Town) ______ (State) ______ (ZIP)

Employer Location Code: ______ Employer Location Name: ______

☐ Please cancel **BASIC** GROUP LIFE INSURANCE thereby canceling all coverage.

SUPPLEMENTAL GROUP LIFE INSURANCE

☐ Please cancel all Supplemental coverage.

☐ Please reduce Supplemental 3 to Supplemental 2.

☐ Please reduce current Supplemental to Supplemental 1.

DEPENDENT GROUP LIFE INSURANCE

☐ Please cancel all Dependent coverage.

☐ Please reduce Dependent B to Dependent A.

I understand that if I wish to reinstate any coverage I have cancelled or reduced, I must furnish, at my own expense, Evidence of Insurability satisfactory to the Maine Public Employees Retirement System.

I also understand my coverage will cease or be reduced at the end of the month in which notice is received by my employer.

Employee Signature: ______________________________ Date: ______________

PLEASE RETAIN A COPY FOR YOUR RECORDS