

# CANCELLATION REQUEST FORM



Insured Name: \_\_\_\_\_

Insurance Account Number: \_\_\_\_\_

Group Policy Number: \_\_\_\_\_

**Cancellation Request.** I request to cancel:

**Initial Here**

- All coverage through my existing life insurance account.\*  
I request that my coverage end on the 1st of \_\_\_\_\_.  
(month/year)
- Only my Term Life insurance.\*  
I request that my coverage end on the 1st of \_\_\_\_\_.  
(month/year)
- Only my Accidental Death coverage.\*  
I request that my coverage end on the 1st of \_\_\_\_\_.  
(month/year)
- Only my Children's coverage.\*  
I request that my coverage end on the 1st of \_\_\_\_\_.  
(month/year)
- Only my Dependent coverage.\*  
I request that my coverage end on the 1st of \_\_\_\_\_.  
(month/year)
- My application for a new term life insurance account.\*\*

\*Requests to cancel in force coverage will be effective the later of the requested effective date or the first of the month following the date the request was received in our office.

\*\*Requests to cancel an application for insurance that is not yet in force will be effective the date the request was received in our office.

Insured/Owner Signature X \_\_\_\_\_ Date: \_\_\_\_\_

**You may send this to us via fax or mail. If you have any questions, please call us.**

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