



## RETIREE LIFE CANCELLATION FORM

Please use this form if you would like to cancel your coverage on the Retiree Life Insurance Plan offered by the UCM Benefits Group. NOTE: Once coverage is cancelled you can not return to plan.

### SECTION 1: Participant Identification

Participant Name: \_\_\_\_\_

Participant SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

### SECTION 2: Termination Information

Termination Effective Date is December 31, \_\_\_\_\_

### SECTION 3: Signature

I hereby certify, by my signature, that in accordance with the UCM Plan, if a retiree terminates participation in the Life Insurance Plan, such covered persons may not become a covered person there after.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**BY MAIL:**

Office of Human Resources  
Benefits  
101 Administration Bldg  
Warrensburg, MO 64093

**BY FAX:**

660-543-4200