Insurance Cancellation Form

Date:

To Whom It May Concern:

I _____ would like to
Name Last 4 of Social Security Number

stop deductions of the following insurance coverage with _____ as of _____.
(Company) (cancellation date)

Policy Type	Group or Policy Number
☐ Basic Life	
☐ Voluntary Life	
☐ Cancer Insurance	
☐ Accident Insurance	
☐ Critical Illness Insurance	Unavailable for the Town of Lincoln
☐ Short Term Disability (STD)	
☐ Long Term Disability (LTD)	
☐ Dental	Unavailable for the Town of Lincoln with LifePlus
☐ Vision	Unavailable for the Town of Lincoln with LifePlus
☐ Hospital Indemnity	Unavailable for the Town of Lincoln
☐ Legal	

_____ _____
Signature Print Name

TOWN OF LINCOLN
Municipality/Company

For School Employees please turn over to the school business office.

For Town Employees please turn over to the town Treasurer's office.

For Office Use Only:
Fax completed form for processing to (781) 837-9227
or mail to 475 School Street, Ste. 5, Marshfield, MA 02050

For Office Use Only

Date **Initials**

_____ Ins. Carrier

_____ Payroll Contact

LIFEPLUS | Hill GROUP