TO: Regence Life and Health

FAX TO: Medical Underwriting (503) 220-3903

GROUP NAME: City of Idaho Falls

POLICY NO: Policy No. ID 03810I

FROM: Employee Name: ______________________________
(Please print)

S.S. Number: ______________________________

Please cancel my:

☐ Employee Voluntary Life – cancellation date _____ _____ _____ (*must be a future date)
Mo Day Yr

☐ Spouse Voluntary Life – cancellation date _____ _____ _____ (*must be a future date)
Mo Day Yr

If cancellation is due to divorce, please give date of divorce _____ _____ _____
Mo Day Yr

☐ Child Voluntary Life – cancellation date _____ _____ _____ (*must be a future date)

______________________________ ____________________
Employee Signature Date

*Voluntary Life coverage cannot be cancelled retroactively. The earliest cancellation date is first of the month following the date this form is signed. In the case of a divorce, coverage will be cancelled first of the month following the date of divorce.