Standard Insurance Company

Termination or Reduction
of Critical Illness
or Accident Coverage

Complete all sections and check all box(es) that apply.

Return form to Risk Management

All changes will be effective October 1, 2024

MEMBER INFORMATION

Your Name (Last, First)	Social Security No.
Group Name **Alachua County Board of County Commissioners**	Group Number **16443**

TERMINATION – cancelling entire policy

Accident	**Critical Illness**
☐ Employee Only ☐ Employee and Spouse ☐ Employee and Children ☐ Employee and Family	☐Employee ☐Spouse

REDUCTION IN COVERAGE AMOUNT – reducing amount or level of coverage

Critical Illness

☐ Employee new requested amount $_____

☐ Spouse new requested amount $ _____

Accident – reduce coverage to

☐ Employee Only

☐ Employee and Spouse

☐ Employee and Children

I wish to reduce or terminate my group insurance coverage as noted above. I understand I may be required to provide Evidence of Insurability at my own expense to increase coverage or become insured again and that Standard Insurance Company will have the right to refuse my request. I understand if I become insured again additional restrictions and limitations my apply.

Member Signature Required	Date