

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

**Return form to Risk Management**

All changes will be effective October 1, 2026

**MEMBER INFORMATION**

Your Name (Last, First)	Social Security No.
Group Name <b>Alachua County Board of County Commissioners</b>	Group Number <b>16443</b>

**TERMINATION – cancelling entire policy**

<p><b>Accident</b></p> <p><input type="checkbox"/> Employee Only</p> <p><input type="checkbox"/> Employee and Spouse</p> <p><input type="checkbox"/> Employee and Children</p> <p><input type="checkbox"/> Employee and Family</p>	<p><b>Critical Illness</b></p> <p><input type="checkbox"/> Employee</p> <p><input type="checkbox"/> Spouse</p>
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**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
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