

REQUEST TO CANCEL INSURANCE PRODUCT(S)

EMPLOYEE: _____
(Print Full Name)

SOCIAL SECURITY NUMBER: _____

INSURED IF OTHER THAN EMPLOYEE: _____

AGENCY: Mississippi State University

EFFECTIVE DATE OF CANCELLATION: _____

- CANCEL COVERAGE ON:
- EMPLOYEE
 - DEPENDENT ONLY (change form required)
 - EMPLOYEE AND DEPENDENTS

CANCEL THE FOLLOWING PRODUCT(S):

- ACCIDENTAL DEATH
- AFLAC CANCER
- AFLAC PERSONAL ACCIDENT
- AFLAC SPECIFIED DISEASE RIDER
- AFLAC HOSPITAL INTENSIVE CARE
- AFLAC CRITICAL CARE
- UNUM Critical Illness
- AMERICAN FIDELITY LONG TERM DISABILITY
- UNUM Whole Life
- CENTRAL UNITED CANCER
- CENTRAL UNITED ICU/CCU
- CNA LONG TERM CARE
- UNIVERSAL LIFE
- UNUM PROVIDENT LONG TERM DISABILITY
Policy No. 574505-001
- Genworth Long Term Care

Employee/Insured Signature

Date