

TERMINATION REQUEST

Your coverage will be cancelled retroactively if the cancellation notice is received within 31 days of the effective date of your new group insurance policy. After the 31-day period, your coverage will terminate upon receipt of your written cancellation notice.

MAIN INSURED

Name:

Identification No.:

Policy No.: 48C00

TERMINATION OF COVERAGE

REASON FOR TERMINATION:

NEW INSURER'S NAME:

NEW POLICY NO. (OR EMPLOYER'S NAME):

EFFECTIVE DATE:

TERMINATION OF COVERAGE FOR DEPENDENTS

DEPENDENTS

First name	Last name	Relation to insured	Reason for termination	Termination date (yyyy-mm-dd)

Signature _____ Date _____

Please complete, sign, and return this form via your **VIGILIS | Secure portal**.

