

Authorization to Cancel Long-Term Care Insurance

(If both employee and spouse request cancellation, both must complete and sign this form)

CNA GROUP LTC POLICY #0010140

THIS FORM MUST BE MAILED TO:

CNA Group Benefits
PO Box 64908
St. Paul, MN 55164

Employee Cancellation:

I request that my Long-Term Care Insurance coverage provided through CNA be cancelled. I understand that I may reapply for coverage at a later date with the following stipulations:

- Premiums will be adjusted to compensate for age
- A medical history questionnaire will be required
- Coverage will be subject to CNA's acceptance

I understand that the effective date of cancellation will be the first of the month following receipt of this form by CNA. If deductions continue after the first of the month, CNA will send a refund to employee.

Associate Name (Print):	Activity:
SSN:	Empl Id:
Signature:	Date:

Spouse Cancellation (If Applicable):

I request that my Long-Term Care Insurance coverage provided through CNA be cancelled. I understand that I may reapply for coverage at a later date with the following stipulations:

- Premiums will be adjusted to compensate for age
- A medical history questionnaire will be required
- Coverage will be subject to CNA's acceptance

I understand that the effective date of cancellation will be the first of the month following receipt of this form by CNA. If deductions continue after the first of the month, CNA will send a refund to employee.

Spouse Name (Print):	
SSN:	
Signature:	Date:

MCCS/CNA USE:

Cancellation Effective Date: _____

CNA Receipt Date: _____

Terminations are adjudicated by CNA and will be audited monthly by MRG.