

TEACHERS AND EMPLOYEES ASSOCIATION
OF KANSAS STATE UNIVERSITY

REQUEST TO CHANGE OR CANCEL INSURANCE POLICY

I wish to reduce my coverage amount to \$ _____.

I wish to cancel my life insurance policy

I wish to cancel dependent coverage on my spouse.
Spouse's printed name:

I wish to cancel dependent coverage on my child(ren).
Child(ren) printed name(s):

I wish to cancel my dependent coverage on my spouse and child(ren).
Spouse and child(ren) printed names:

Employee's Printed Name

Employee's ID Number

Employee's Signature

Date

Return completed form to: TEA, 103 Edwards Hall, Manhattan, Kansas 66506.