

TO: EMPLOYEE BENEFITS DEPARTMENT

Added during current Open Enrollment Yes _____ No _____

Currently enrolled from prior year Yes _____ No _____

I WOULD LIKE TO CANCEL MY UNUM LONG TERM CARE.

NAME: _____ **EMP.#** _____

SIGNATURE _____ **DATE** _____

UPON COMPLETION

FAX TO: 390-2566

OR

SCHOOL MAIL TO: 3001 EMPLOYEE BENEFITS DEPARTMENT

EMPLOYEE BENEFITS USE ONLY

TERM AND REFUND DATE(S) _____

COPY TO FBMC (DATE) _____

NOTATE IT 376 (DATE) _____