

**SUPPLEMENTAL LIFE INSURANCE DECREASE/CANCELLATION FORM**

Employee Name: \_\_\_\_\_ Work Location: \_\_\_\_\_  
Please Print Last, First (Agency/Department)

Employee Address: \_\_\_\_\_ SS# \_\_\_\_\_  
Street City State Zip

Employee Phone (Work): \_\_\_\_\_ Employee Phone (Home): \_\_\_\_\_

Check Appropriate Box(es)      Decrease Employee Coverage       Cancel Employee Coverage   
Decrease Spouse Coverage       Cancel Spouse Coverage   
Decrease Child(ren) Coverage       Cancel Child(ren) Coverage

**SUPPLEMENTAL LIFE- (\$10,000) increments to a max of \$300,000 for employees**

NAME OF COVERED EMPLOYEE	SOCIAL SECURITY #	DATE OF BIRTH (MM/DD/YY)	CURRENT AMOUNT IN FORCE	TOTAL AMOUNT REQUESTED
	- -		\$	\$

**DEPENDENT LIFE SPOUSE**

Dependent Spouse- \$5,000 increments up to a maximum of the lesser of 50% of spouse supplemental life to a maximum benefit of \$50,000

NAME OF COVERED SPOUSE	SOCIAL SECURITY #	DATE OF BIRTH (MM/DD/YY)	CURRENT AMOUNT IN FORCE	TOTAL AMOUNT REQUESTED
	- -		\$	\$

**DEPENDENT LIFE CHILD(ren)**

Dependent Child(ren) amount is \$1.90/month for \$10,000.00 worth of coverage

NAME OF COVERED DEPENDENT(S)	SOCIAL SECURITY #	DATE OF BIRTH (MM/DD/YY)	CURRENT AMOUNT IN FORCE	TOTAL AMOUNT REQUESTED
	- -		\$	\$
	- -		\$	\$
	- -		\$	\$
	- -		\$	\$
	- -		\$	\$

Please attach additional pages if necessary

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please note, any changes to supplemental life coverage must be received by the Benefits Department at the address above by May 23, 2008. Failure to submit changes in writing within the deadline will result in coverage defaulting to the current level. **Requests for increases** must be submitted to MetLife via the Statement of Health Form.