**AMALGAMATED VOLUNTARY BENEFITS CANCELLATION FORM**

**Amalgamated Coverages**

**Do you wish to cancel your Amalgamated Accident Coverage?** Yes  No

**Do you wish to cancel your Amalgamated Critical Illness Coverage?** Yes  No

**Do you wish to cancel your Amalgamated Disability Coverage?** Yes  No

**Do you wish to cancel your Amalgamated Workers Life Coverage?** Yes  No

**Security Mutual Life Insurance Coverage**

**Do you wish to cancel your Security Mutual Life Insurance Coverage?** Yes  No

**Please fax or email this form to:**

**Silvia Aguilar**

**Fax: xxx-xxx-xxxx**

**Email: saguilar@honestbenefits.us**

**Phone: 626.695.7018**

***To process this cancellation, the information below must be provided:***

**Your Name (Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1st 5 digits of SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Note: If you remit premium via payroll deduction, it can take at least 2 payroll periods to stop deduction.