



REQUEST TO CANCEL INSURANCE

COLONIAL SUPPLEMENTAL

Printed Name: _____

Munis ID: _____

Effective Date: _____

- ☐ Short Term Disability
- ☐ Accident
- ☐ Cancer
- ☐ Critical Illness
- ☐ Cancel all Colonial Benefits

Signature

Date

*If your Colonial premiums are pre-taxed, your cancellation will be effective the following January 1.

*Open enrollment occurs each November.

*Please return completed form to the Benefits Office.