TERMINATION REQUEST FORM

Please select the coverage(s) for termination: *

*Termination requests go into effect the first of the following month from receipt of Termination Request Form.

____ Long-Term Disability ____Short-Term Disability ____ Life Insurance

Member Name (please print): ____

Employer Name/Location: ____

Employee ID/Last 4 digits of SS#: ____

Home Address: ____

City, State, Zip Code: ____

Contact Phone Number: ____

Reason for Termination: ____

Signature____________________________________ Date____________________

Send Completed Form To:

Theresa Reyes
Associated Consulting Group
147 Union Street
Brooklyn, NY 11231
Phone: 212-679-9807 ext. 4
Fax: 212-658-9662
E-Mail: treyes@acgnyc.com

If you do not have access to a secure email, please send form via fax only.