

Authorization to Cancel Long-Term Care Insurance

(If both employee and spouse request cancellation, both must complete and sign this form)

CNA GROUP LTC POLICY #0010140

THIS FORM MUST BE MAILED TO:

HEADQUARTERS U.S. MARINE CORPS
ATTN: JANIE BABB
PERSONAL & FAMILY READINESS DIVISION (MRG)
3044 CATLIN AVENUE
QUANTICO, VA 22134

Fax: (703) 432-0436

For questions please call: 703-432-0438

Employee Cancellation:

I request that my Long-Term Care Insurance coverage provided through CNA be cancelled. I understand that I may reapply for coverage at a later date with the following stipulations:

- Premiums will be adjusted to compensate for age
- A medical history questionnaire will be required
- Coverage will be subject to CNA's acceptance

I understand that the effective date of cancellation will be the 1st of the next month following receipt of this form by the Personal and Family Readiness Division at MCCS Headquarters.

Associate Name (Print):	Activity:
SSN:	Empl Id:
Signature:	Date:

Spouse Cancellation (If Applicable):

I request that my Long-Term Care Insurance coverage provided through CNA be cancelled. I understand that I may reapply for coverage at a later date with the following stipulations:

- Premiums will be adjusted to compensate for age
- A medical history questionnaire will be required
- Coverage will be subject to CNA's acceptance

I understand that the effective date of cancellation will be the 1st of the next month following receipt of this form by the Personal and Family Readiness Division at MCCS Headquarters.

Spouse Name (Print):	
SSN:	
Signature:	Date:

MCCS/CNA USE:

Cancellation Effective Date: _____

MRG Receipt Date: _____

Terminations are adjudicated by CNA and will be audited monthly by MRG.