

WA State Health Care Authority PEBB Customer Number 164995

PEBB cancellation of Supplemental Life and AD&D insurance through MetLife

Use this form to notify MetLife that you wish to cancel your Supplemental Life Insurance or Supplemental Accidental Death & Dismemberment (AD&D) Insurance.

Basic Life Insurance (\$35,000) and Basic AD&D Insurance (\$5,000) is not affected by this form. Basic Life and AD&D are provided by your employer at no cost to you.

You cannot cancel your Supplemental Life Insurance and keep Dependent Life Insurance. However, you may keep your Supplemental Life Insurance and Supplemental AD&D Insurance and cancel coverage for your spouse or state-registered domestic partner and/or dependent child(ren).

Employee information		
Name (first, middle, last)		Social Security number
Address (street, city, state, ZIP Code)		
Date of birth (MM/DD/YYYY)	Phone number	Alternate phone number (optional)
Cancellation options		
Please check the insurance below you wish to cancel.		
Cancel my employee coverage:		
<input type="checkbox"/> Supplemental Life Insurance		
<input type="checkbox"/> Supplemental AD&D Insurance		
Cancel coverage for my spouse or state-registered domestic partner:		
<input type="checkbox"/> Supplemental Spouse/State-Registered Domestic Partner Life Insurance		
<input type="checkbox"/> Supplemental Spouse/State-Registered Domestic Partner AD&D Insurance		
Cancel coverage for my child(ren):		
<input type="checkbox"/> Supplemental Child Life Insurance		
<input type="checkbox"/> Supplemental Child AD&D Insurance		
Signature		
By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. This crime can result in imprisonment, fines, and denial of benefits. I understand that coverage cancellation will be effective on the first of the month following receipt of this signed and dated form.		
I understand the information collected about me is confidential. MetLife will not release any information about me without my authorization, except to conduct business or as required or permitted by law.		
Employee signature: _____		Date _____

Make a copy for your records and return the original form to:
 MetLife Recordkeeping Center, PO Box 14406, Lexington, KY 40512