Union Benefit Planners
100 Matawan Road ~ Suite 200
Matawan, New Jersey 07747

Request for Surrender

Social Security Number:	Employee Identification Number:		Policy Number (s):
Owner's Name: (Last, First, M.I.)			
Insured's Name: (Last, First, M.I.)			
Insured's Name: (Last, First, M.I.)			
Home Address:			
City	State	Zip Code	Phone Number ( ) -

Insurance Carrier: **STANDARD DISABILITY PLAN/AA**

I/We hereby surrender said Contract(s) for cancellation. In accordance with the surrender of the said Contract(s), I understand that payroll deductions will cease within 4 to 6 weeks.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

Owner Signature _____ Witness _____

Spouses* Signature _____ Witness _____
(Required in Community property states.)

Assignee (if applicable) _____ Witness _____

THE REQUEST MUST BE DATED the day it is signed and all signatures must be written in full exactly as they appear in the Contract and must be in ink. In the case of a woman who has been married since the contract was issued, her signature should be completed by adding her present name to the name as it appears in the contract. All signatures must be separately witnessed.

Return Completed Form to:

Union Benefit Planners
100 Matawan Road, Suite 200
Matawan, NJ 07747-3914
888-602-6628

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS

** If married, spouse (spouse or equivalent, as defined by governing state law) of Policy Owner must sign if residence is in one of the community property states of: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin.*