

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: <b>STANDARD DISABILITY PLAN/TWU</b>
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 _____ (Required in Community property states.)	Witness _____
Assignee (if applicable) _____	Witness _____
<p><i>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.</i></p>	

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.*