maine PERS Public Employees Retirement System

46 State House Station
Augusta, ME 04333-0046

Telephone (207) 512-3100
Toll-free: 1-800-451-9800
TTY: (207) 512-3102

CANCELLATION/REDUCTION IN COVERAGE

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth: _____

Name: _____
(Print or Type) Last First Middle

Address: _____
Mailing Address City State Zip Code

Place of Employment: _____
State Department/School Unit/Participating Local District

☐ Please cancel **BASIC** GROUP LIFE INSURANCE thereby canceling all coverage.

SUPPLEMENTAL GROUP LIFE INSURANCE

☐ Please cancel all Supplemental coverage.

☐ Please reduce Supplemental 3 to Supplemental 2.

☐ Please reduce current Supplemental to Supplemental 1.

DEPENDENT GROUP LIFE INSURANCE

☐ Please cancel all Dependent coverage.

☐ Please reduce Dependent B to Dependent A.

I understand that if I desire to reinstate any of the coverage I have cancelled or reduced, I must furnish, at my own expense, Evidence of Insurability satisfactory to the Maine Public Employees Retirement System.

I also understand my coverage will cease or be reduced at the end of the month in which notice is received by my employer.

Date: _____ Employee Signature: _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

Form# GI-0881
Rev. 02/08

INSTRUCTIONS FOR CANCELLATION/REDUCTION IN COVERAGE

(Form # GI-0881)

Please type or clearly print (in ink) all of the following information in a legible manner.

- **Social Security Number:** Enter the employee's nine digit Social Security Number.
- **Date of Birth**: Enter the employee's date of birth in the following format: two-digit month - two-digit day - four-digit year.
- **Name**: Enter the employee's full name. (Last name, first name, middle initial)
- **Address:** Enter the employee's complete mailing address.
- **Place of Employment:** Enter the employer's name (Example: Department of Labor, Augusta School Department, or City of Bangor).
- **Supplemental Group Life Insurance:** Check the box that applies to the employee's cancellation or reduction in coverage in supplemental coverage.
- **Dependent Group Life Insurance:** Check the box that applies to the employee's cancellation or reduction in dependent coverage.
- **Date:** Enter the date the form was completed and signed.
- **Employee Signature:** This line is for the employee's signature.