CITY OF DALLAS
CLIENT # 3202
EMPLOYEE CANCELLATION/CHANGE FORM

Please PRINT all information

_____ _____
Employee Name Insured's name if other than Employee

_____ _____
Employee Social Security # Employee Number if other than SS#

_____
Street Address City State Zip Code

_____ _____
Home Telephone Number Policy Number(s), If Known

Employee Name Change

Former Name _____

New Name _____

Date of Change_____

Employee Change of Address

Old Address _____ New Address _____

_____ _____

_____ _____

Old Phone_____ New Phone_____

EFFECTIVE DATE: _____

PLEASE CANCEL COVERAGES AS REQUESTED FOR:

Trustmark Individual Disability
- □ **Employee**
- □ **Spouse**
- □ **All Coverage**

Legal Club of America
- □ **All Coverage**

Transamerica Intensive Care
- □ **All Coverage**

Transamerica Universal Life
- □ **Employee**
- □ **Spouse**
- □ **All Coverage**

Monumental Long Term Care
- □ **All Coverage**

_____/_____ _____
EMPLOYEE SIGNATURE **DATE**
(Please Print & Sign)

Please return completed form by fax or mail to:

NATIONAL WORKSITE ADVANTAGE
1035 W. GLEN OAKS LANE
SUITE 200
MEQUON, WI. 53092
FAX: (262) 404-0000
Phone: (262) 404-1003 or 800-514-3446