Request to Terminate Firm Coverage

FIRM INFORMATION

Firm Name _____ Firm # _____

Termination Request Date (YYYY/MM/DD) _____

Reason for Termination _____

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The Member Firm may terminate its coverage "as of" the first of any month, as per the Master Contracts and your Administration and Claims Guide. The Plan Administrator must be notified in writing of the Member Firm's intent to terminate coverage at least 30 days prior to the requested date of termination.

AUTHORIZATION (MUST BE SIGNED BY THE OWNER/AUTHORIZED OFFICIAL)

Authorized Official Signature _____

_____ Date _____

Please print your name and title YYYY/MM/DD

Desjardins Insurance and Sutton Special Risk/Lloyd's are the primary insurers for the Plan.
Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company