Reduction or Discontinue Coverage Form

Insured Name

First Name Middle Name Last Name

Policy/ies Number or Social Security Number:

Which coverage would you like to reduce/discontinue?

	Yes	No	Reduce Benefit	New Deduction
Disability Pro - Paycheck Protection	☐	☐	☐ _____	☐ _____
Accident Pro	☐	☐	☐ _____	☐ _____
Critical Illness Pro	☐	☐	☐ _____	☐ _____
One Life Pro (Universal Life)	☐	☐	☐ _____	☐ _____
Hospital Indemnity	☐	☐	☐ _____	☐ _____
Cancer Expense	☐	☐	☐ _____	☐ _____
Term Life	☐	☐	☐ _____	☐ _____
Whole Life	☐	☐	☐ _____	☐ _____
Discontinue All Plans	☐	☐	☐ _____	☐ _____

Reason for reduction or discontinuance

Leaving School District	☐
Found a better plan	☐
Can't afford coverage	☐
Other	☐

Comments:

**Please print this form out, sign-it and send it via email or fax to:*
Email admin@unitedschools4u.com Fax 202.318.4750

**Please remember to destroy all discontinued policies in your possession as of the effective date requested*

Account Holder Signature		**Date:**	

UNITED SCHOOLS ASSOCIATES INC.

16701 Melford Boulevard, Suite 400, Bowie, MD 20715
Voice (844) USA-4YOU (872-4968) Fax 202.318.4750