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
Group Disability Income - Paycheck Protection	☐	☐	☐ _____	☐ _____
Group Accident	☐	☐	☐ _____	☐ _____
Group Critical Illness	☐	☐	☐ _____	☐ _____
Group Universal Life	☐	☐	☐ _____	☐ _____
Group Whole Life	☐	☐	☐ _____	☐ _____
Active Care	☐	☐	☐ _____	☐ _____
Term Life	☐	☐	☐ _____	☐ _____
Other	☐	☐	☐ _____	☐ _____
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 info@usa4you.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