Termination of Prudential Long Term Disability Coverage

Employee Name: _____

Employee ID: _____

Last 4 Digits of SSN: _____

Please cancel my Prudential Long Term Disability coverage effective

_____.

The effective date of coverage termination must be the first of a month.
The effective date of coverage termination must be the first of the month following the date of the request or after.

Employee Signature: _____

Date of Request: _____

<u>For Employer's Use Only</u>

Entered in PS by: _____

Date Entered in PS: _____