

# TWU-USW EMPLOYEE LIFE AND HEALTH PLAN CANCELLATION OF COVERAGE

#303-4603 Kingsway, Burnaby, B.C. V5H 4M4

**MEMBER NAME:** \_\_\_\_\_ **SIN:** \_\_\_\_\_  
(PLEASE PRINT) (Surname)

**GIVEN NAME:** \_\_\_\_\_ **HOME PHONE:** \_\_\_\_\_  
(IN FULL)

**PREVIOUS NAME:** \_\_\_\_\_  
(IF APPLICABLE)

**ADDRESS:** \_\_\_\_\_

**CITY/PROV:** \_\_\_\_\_ **POSTAL CODE:** \_\_\_\_\_

<b>DATE OF BIRTH :</b>		MONTH		DAY		YEAR		<b>SEX:</b> MALE <input type="checkbox"/>	<b>EMPLOYEE</b>	<input style="width: 100%;" type="text"/>
								FEMALE <input type="checkbox"/>	<b>ID:</b>	

- TEMP MEMBER (PLAN B)** - Group Life Insurance & Survivor Income Benefit
- REGULAR MEMBER (PLAN B & C)** - Group Life Insurance & Survivor Income Benefit & Short Term Disability Benefit

If you wish to withdraw from the Plan on the foregoing basis, please complete this form, sign the acknowledgment below, and complete the waiver form. We will notify Telus Payroll to stop deductions to the Plan at the effective date. *(Note: This cancellation form cannot be backdated).*

At a future date, you may again become a participant of the Plan only on submission of the required medical evidence, satisfactory to BC Life & Casualty, the Plan's Insurance Company.

**I hereby acknowledge that I fully understand the basis described in this form upon which my participation in the Plan will terminate, and I confirm my desire to cease participation.**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**MEMBER SIGNATURE**

**RETURN ORIGINAL TO:** TWU-USW ELHP  
303-4603 KINGSWAY, BURNABY, B.C. V5H 4M4

**PHONE:** 604-430-3300

