Department of Human Resources

LIFE INSURANCE TERMINATION FORM
FOR RETIREES

Complete this form if you are a City retiree and wish to terminate your supplemental and/ or dependent life insurance coverage. **If you want to keep your current coverage, no action is necessary.**

SUPPLEMENTAL LIFE INSURANCE

Place an "X" on the line below ONLY if you want to terminate your supplemental life insurance coverage.

_____ I hereby terminate my supplemental life insurance. I understand that this decision is final and I will not be able to re-enroll in supplemental life insurance coverage. I also understand that Basic (City-paid) life insurance I have will remain in force, subject to applicable age reductions.

DEPENDENT LIFE INSURANCE

Place an "X" on the line below ONLY if you want to terminate your dependent life insurance coverage. Dependent life insurance covers your spouse and/or child(ren) up to age 26. You are the beneficiary for this coverage.

_____ I hereby terminate life insurance for my dependent(s). I understand that this decision is final and I will not be able to re-enroll in dependent life insurance coverage.

COMPLETE AND SIGN

_____ _____
Print Name Date

_____ _____
Signature Phone

_____
Email address

RETURN TO:

Department of Human Resources, ATTN: Benefits
By mail: 2331 Mill Road, Room 301, Alexandria, VA 22314
By email: DHR.Benefits@alexandriava.gov