ILLINOIS STATE UNIVERSITY

HUMAN RESOURCES

PRUDENTIAL LONG TERM DISABILITY CANCELLATION FORM

Group Number: 92821

EMPLOYEE SECTION

Name: _____ UID#: _____

Address: _____

City: _____ State: _____ Zip:_____

CANCELLATION of policy: (Select appropriate option)

☐ Canceling policy only, not employment**

Cancellation of policy will be effective on the first day of the following month from when a signed cancellation request is received. Requests **received on the first day of the month will be cancelled effective immediately.

Signature of Employee: _____ Date: _____

Return completed form to:

Human Resources, Illinois State University
Campus Box 1300
Normal, Il 61790-1300