ACRISURE®

Request for Surrender

Email Address:	Employee Identification Number:		Policy Number (s):
Owner's Name: (Last, First, M.I.)			
Insured's Name: (Last, First, M.I.)			
Insured's Name: (Last, First, M.I.)			
Home Address:			
City	State	Zip Code	Phone Number ( ) -

Insurance Carrier: _____

Type of Policy: ☐ Permanent Life ☐ Term Life ☐ Long Term Disability ☐ Short Term Disability ☐ Accident ☐ Dental ☐ Cancer Plan ☐ Critical Illness ☐ Identity Theft ☐ Hospital Indemnity

I/We hereby surrender said Contract(s) for cancellation. In accordance with the surrender of the said Contract(s), I understand that payroll deductions will cease within 4 to 6 weeks.

Universal Life/ WrapPlan Policies:

In accordance with the terms of the Contract, it is hereby agreed that any indebtedness thereon to the Company will be deducted from the (Cash) (Maturity) Value.

Said (Cash) (Maturity) Value is accepted in full settlement and complete satisfaction of all rights, claims and demands, under said Contract.

It is expressly represented and warranted that no other person, firm or corporation has any interest in said Contract except the undersigned and that no proceedings in insolvency or bankruptcy have been instituted or are pending against the undersigned.

Signed in (City/State) _____ This ____ Day of (Month/Year) _____

Owner Signature _____ Witness _____

Spouses* Signature _____ Witness _____
(Required in Community property states.)

Assignee (if applicable) _____ Witness _____

THE REQUEST MUST BE DATED the day it is signed and all signatures must be written in full exactly as they appear in the Contract and must be in ink. In the case of a woman who has been married since the contract was issued, her signature should be completed by adding her present name to the name as it appears in the contract. All signatures must be separately witnessed.

Return Completed Form to Acrisure at...

FAX - 866-910-5078 EMAIL - info@unionbenefitplanners.com

MAIL - 65 Madison Ave, Morristown, NJ 07960