Request to Decrease or Cancel Group Accident Plan (GAP) Coverage

Compass Rose Benefits Group
11490 Commerce Park Drive
Suite 220
Reston, VA 20191
FAX: (888) 972-1853

Please complete this form if you wish to decrease or cancel your existing Group Accidental Plan (GAP).

Check one of the boxes below and complete the associated fields.

☐ **I wish to DECREASE my Group Accident Plan (GAP) coverage.**

Current Coverage Amount: $_____

New Coverage Amount: $ _____

☐ **I wish to CANCEL my Group Accident Plan (GAP) coverage.**

Please provide the reason(s) you wish to cancel your coverage: _____

_____

_____

_____

_____

_____

_____

First Name MI Last Name

_____ _____

Date of Birth (MM/DD/YYYY) Last 4 Digits of Social Security Number

_____ _____

Insured's Signature Date