

To: CNA Long Term Care

From: _____
Employee Name (Print) SSN
City of Tallahassee

Subject: Long Term Care Plan Enrollment Change or Cancellation

Per my signature below, I am requesting the following:

- My daily coverage level be reduced from \$_____ to \$_____
- My spouse's and my daily coverage level be reduced from \$_____ to \$_____
- Termination of my enrollment in long term care.
- Termination of my **spouse's** enrollment in long term care

Print Name of Spouse

Effective Date: _____

Signature of Employee

Date

Signature of Spouse

Date

(Required if spouse coverage terminates or spouse's level of coverage is reduced)