KAISER PERMANENTE®
Southern California Permanente
Medical Group

Retiree Tapered Life Insurance
Request to Reduce Coverage to $50,000 Retiree Life Form

Name: _____ (Please print)

Address: _____

City, State, Zip; _____

Last 4 digits of your Social Security Number: _____

Please initial each of the following:

_____I acknowledge that my election to reduce coverage is irrevocable.

_____ I request to reduce my Tapered Life Insurance to the **$50,000** Retiree Life Insurance

I understand that my decision to reduce my insurance coverage of **$662,558** as of 7/1/2018 is irrevocable. The higher coverage amount cannot be reinstated at a later date. If you are attempting to place another policy, do not change coverage until your replacement coverage is active.

Coverage will be reduced on the first day of the month following receipt of your properly completed Request to Reduce Coverage Form. If you have questions on the completion of this form, please call 1-877-608-0044.

_____ _____

Signature Date