

Ashlor Benefit Cancellation Notice

Date: _____

I, _____, do hereby request

(print name of insured)

cancellation of my _____

(Health Insurance, Legal Shield, Life Insurance, AFLAC--Accident, Cancer, Dental , Vision, other)

Cancellation effective first of the month: _____

Insured's signature: _____

Associate name/signature: _____

Benefits Your Way

Email to: garlandgrazier@gmail.com or mwalz1968@gmail.com

Fax to: 888-777-0971