

Premium Only Plan (Symetra)

### Revocation of Benefit Election Form

Employer Name: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Effective \_\_\_\_\_ I hereby revoke my benefit election and compensation redirection agreement under the Premium Plan Only with respect to the following benefit coverage (s).

- Health Benefit
- Dental Benefit
- Group Term Life Benefit
- Disability Benefit
- Cancer Benefit
- Vision Benefit
- Accidental death/dismemberment Benefit
- Heart Care

Coverage named below: (must be approved by Plan Administrator)

\_\_\_\_\_

My benefit election and compensation redirection agreement shall remain in effect as to my benefit coverage, if any, which are not checked above.

\_\_\_\_\_  
Employee Signature \_\_\_\_\_  
Date

Accepted and agreed to by \_\_\_\_\_  
Administrator

\_\_\_\_\_  
By \_\_\_\_\_  
Date

This revocation may not be effective prior to the first day of the next Plan Year unless it is made because of a change of family status as defined in the Plan. In no event may the revocation be effective prior to the first pay period beginning after this form is completed and returned to the Plan Administrator.