laborfirst

LABOR FIRST INSURANCE CANCELLATION REQUEST

Plan Sponsor:	WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN
Name of Insured:	
Carrier & Plan Type:	UNITEDHEALTHCARE MAPD
Date of Cancellation:	

To Labor First,

Please cancel my insurance policy (or policies) as indicated on the date specified above.

Sincerely,

Signature:	
Date of Birth:	
Date:	

Please mail, fax or email this form to:

Labor First, LLC

1000 Midlantic Drive, Suite 100

Mount Laurel, NJ 08054

Fax: (856) 437 – 4550

E-Mail: krooney@laborfirst.com or members@laborfirst.com