ILLINOIS STATE UNIVERSITY
HUMAN RESOURCES
PRUDENTIAL LONG TERM DISABILITY CANCELLATION FORM

Group Number: 92821

EMPLOYEE SECTION

Name: ___________________________________________ UID#: ______________________

Address: _____________________________________________________________________

City: _______________________________ State: ___________ Zip:_____________________

CANCELLATION of policy: (Select appropriate option)

☐ Canceling policy only, not employment**

**Cancellation of policy will be effective on the first day of the following month from when a signed cancellation request is received. Requests received on the first day of the month will be cancelled effective immediately.

Signature of Employee: ___________________________ Date: ______________

Return completed form to:

Human Resources, Illinois State University
Campus Box 1300
Normal, IL 61790-1300