RetireeFirst

RetireeFirst Insurance Cancelation Request

Plan Sponsor:	WISCONSIN ELECTRICAL EMPLOYEES
Name of Insured:	
Carrier & Plan Type:	United HealthCare MAPD
Date of Cancellation	

To RetireeFirst,
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:
Retireefirst, LLC
1000 Midlantic Drive, Suite 100
Mount Laurel, NJ 08054
Fax: (856) 437-4550

Plan TypeCarrier Code_Year_Type_Group Name_Document Type