



Better Insurance. Better Prices. Better Value.®

Reduce Amount of Coverage Form

Please provide a home address only, due to past rejected mailings to office addresses.

* Certificate Number: _____

* Full Name: _____

* Phone Number: _____

Email Address: _____

* Address: _____

City: _____

State: _____

Zip: _____

* Current Amount of Coverage

Member: _____ (Amount of Member Life Insurance)

Dependent: _____ (Amount of Spouse/DomesticPartner Life Insurance
Dependent coverage may not be greater than half (50%) of member coverage)

* Reduce Coverage Amount To

Member: _____ (Amount of Member Life Insurance)

Dependent: _____ (Amount of Spouse/DomesticPartner Life Insurance
Dependent coverage may not be greater than half (50%) of member coverage)

* Effective Date of Reduction: _____

Please note: Our computer system does not permit us to make changes in advance of the current month. Your request will be processed in the month of the reduction request.

* Required Information

Signature: _____ Date: _____

Please Sign and Date your request, and Mail it to:

Worldwide Assurance for Employees of Public Agencies
433 Park Avenue
Falls Church, VA 22046

Or for faster service Email your request to info@waepa.org

You can contact WAEPA TOLL FREE at (800) 368-3484,
or view the WAEPA website at: www.WAEPA.org