**(Must be received by the Plan Office prior to the Retirement Date)**

**Phone: (855) ASK-4MPI or (855) 275-4674**

|  |  |
| --- | --- |
|  |  |

To the Board of Directors of the Motion Picture Industry Pension Plan (“Pension Plan”) and Motion Picture Industry Account Plan (“IAP”) (collectively “the Plans”):

**This is to confirm that I,** **{stdMbrFullName}, intend to CANCEL my Retiree Health Application with the Retirement Date of** **{RetrDate}.**

I understand that if my completed cancelation form is not received by the Plans before the Retirement Date indicated above, I will no longer be able to cancel my Retirement Application.

I understand that if my Retiree Health Application is canceled, I must re-apply for retirement benefits from the Plans and give the Plans at least two (2) calendar months notice of my intention to do so.

|  |  |  |  |
| --- | --- | --- | --- |
| Participant's Signature: |  | Date: |  |

**PLEASE READ CAREFULLY BEFORE SIGNING**

**Please submit this form in timely manner, ONLY if you wish to cancel your**

**Retiree Health Application with the Retirement Date indicated above.**

{CurrentDate}

{x stdMbrAdrCorStreet1}

{x stdMbrAdrCorStreet2}

{x if stdIsUSA = 1}

{x stdDomesticStateInternationalCountry}

{x else}

{x stdDomesticStateInternationalCountry}

{x stdMbrAdrCountryDesc}

{endif}

Dear {stdTitle} {stdMbrLastName},

{stdLoggedInUserFullName}