COMBINED INSURANCE

REVOCATION OF APPOINTMENT OF REPRESENTATIVE

POLICYHOLDER NAME

POLICYHOLDER ID #

I hereby revoke my Authorization dated

which authorized the following individual(s) to obtain Information concerning my coverage with Combined Life Insurance Company of New York:

NAME

ADDRESS

NAME

ADDRESS

NAME

ADDRESS

POLICYHOLDER SIGNATURE

DATE

Please mail the completed form to the address below or fax to 312-351-6940.