

CANCELLATION NOTICE

Name: _____

Social Security # _____

District: _____ Campus: _____

Effective _____ payroll, I hereby cancel my premium deduction with respect to the following coverages and amounts:

INSURANCE COVERAGE

<u>AMOUNT</u>	<u>TYPE OF COVERAGE</u>	<u>NAME OF INSURANCE COMPANY</u>
\$ _____	Accidental Death/Dismemberment	_____
\$ _____	Cancer coverage	_____
\$ _____	Dental coverage	_____
\$ _____	Disability coverage	_____
\$ _____	Life coverage	_____
\$ _____	Medical coverage	_____
\$ _____	_____	_____
\$ _____	_____	_____

NON-INSURED COVERAGE

<u>AMOUNT</u>	<u>TYPE OF COVERAGE</u>	<u>NAME OF INSURANCE COMPANY</u>
\$ _____	Medical expense reimbursement	_____
\$ _____	Dependent care assistance	_____
\$ _____	Tax Sheltered Annuity (403B)	_____
\$ _____	_____	_____
\$ _____	_____	_____

My premium deductions shall remain in effect as to any coverages, which are not checked above.

Employee's Signature

Date