

REQUEST FOR CANCELLATION OF INSURANCE FAYETTE COUNTY PUBLIC SCHOOLS

Employee Name:	S.S. #
Work Location:	Effective 1/1/10

I would like to cancel the following insurance coverage(s). I understand by signing this form, I am authorizing the school district to cancel my payroll deduction(s) for the coverage(s) listed below and that any other payroll deductions will remain the same.

INSURANCE CARRIER	TYPE OF INSURANCE	CHECK TO CANCEL
Delta Dental	Dental	<input type="checkbox"/>
Davis Vision	Vision	<input type="checkbox"/>
Monumental Cancer Check	Cancer	<input type="checkbox"/>
Unum	Disability	<input type="checkbox"/>
Unum	Term Life	<input type="checkbox"/>
Unum	AD&D	<input type="checkbox"/>
Flexible Spending Accounts		Automatically cancelled. Must reenroll every year.

Employee Signature

Date