



THE SCHOOL DISTRICT OF
PALM BEACH COUNTY, FLORIDA

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Request to Terminate Voluntary Plans

Please place a check mark in the box next to each plan that you wish to cancel. The coverage will be terminated at the end of the month upon receipt of this form.

- Employee Optional Life
- Spouse Optional Life
- Dependent Optional Life
- Other _____
- Short Term Disability
- Long Term Disability
- Over Aged Adult Child
- Domestic Partner Coverage
 - Medical
 - Dental
 - Vision

I acknowledge that I will not be permitted to re-enroll myself or my dependents in these plans until the next Annual Enrollment. I must complete and submit a Statement of Health Application to be considered for Life insurance coverage in the future for myself and/or my eligible dependents. The life insurance carrier will determine enrollment eligibility.

Employee's Name – (clearly printed)

Employee I.D.

Employee's Signature

Date

+++++
For Office Use Only – Please do not write below this section
+++++

- Terminated in PeopleSoft _____
Date
- Submitted for Scanning _____
Date
- Terminated effective _____
Date
- Technician's initials: _____

Risk & Benefit Management Date Stamp

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