Request to Terminate Voluntary Plans

Please place an **X** 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.

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

I acknowledge that I may not be permitted to re-enroll myself or my dependents in the above plan(s) until the next Annual Open Enrollment.

I understand that should I apply in the future to re-enroll the Option Life plan that is being terminated that enrollment would require a submission of 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

Risk & Benefit Management Date Stamp

☐ Submitted for Scanning _____ Date

Terminated effective _____ Date

Technician's initials: _____