CANCELLATION REQUEST FORM

Employer Name ______________________________

Account Number ______________________________

Insurance Carrier ______________________________

I, ______________________________ **wish to cancel my current insurance policy or policies as follows.**
(Please Print)

*****If applicable***** *I understand I may not be able to cancel this coverage until the next anniversary of my employer's Section 125 Cafeteria Plan* ***IF*** *my deduction is pre-taxed*

Policy Type: ____________ **Policy #:** ____________

Policy Type: ____________ **Policy #:** ____________

Policy Type: ____________ **Policy #:** ____________

Policy Type: ____________ **Policy #:** ____________

Effective Date of Cancellation ______________________________

*** I understand that my deductions will be stopped as of the requested effective date listed above ***

Reason for Cancellation:

- ☐ **Divorce** ____________ **Date of Divorce**
- ☐ **Marriage** ____________ **Date of Marriage**
- ☐ **Open Enrollment** ____________ **Plan Year**
- ☐ **Other (please explain):** ______________________________

Insured Signature ______________________________

Date of Signature ______________________________

Benefit Specialist Name ______________________________

Payroll Account Authorization ______________________________
if Applicable **Signature**

____
Print Name

____
Date of Signature

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