



## GROUP INSURANCE CANCELLATION REQUEST

To notify the Board, complete this form when:

- \* For personal reasons you no longer want group insurance through the Board
- \* You are a Secondary teacher hired to full time prior to 1990 or are within 100 days of retirement and you want to cancel your LTD insurance.

EMPLOYEE I.D. NUMBER		EMPLOYEE NAME
LOCATION	POSITION	SOCIAL INSURANCE NUMBER

This form is to be used for cancellation of your group insurance coverages only.  
 The information collected on this form is in accordance with Section 28 of the Municipal Freedom of Information and Protection of Privacy Act (1989) for the purpose of updating employee benefit plans.  
 In accordance with the terms of the Collective Agreement and/or the contract between the Board and the applicable benefit carrier, you are hereby authorized to cancel the following benefit plans:

**Basic Life Insurance (BLICNFD)**

Reason \_\_\_\_\_

**Optional Life Insurance (OPTCNFD)**

Reason \_\_\_\_\_

**Dependent Life Insurance (DEPCNFD)**

Reason \_\_\_\_\_

**Accidental Death & Dismemberment Insurance (ADDUNUM)**

Reason \_\_\_\_\_

**Long Term Disability Insurance (LTDOTIP/MUTL)**

Reason \_\_\_\_\_

EMPLOYEE SIGNATURE _____		DATE SIGNED _____	
FOR BOARD USE ONLY	PAYROLL - BENEFITS PROCESSED BY:	DATE PROCESSED	EFFECTIVE DATE OF CHANGE

CAT # 20 600 31

**BOARD COPY – PAYROLL BENEFITS CLERK**

**EMPLOYEE COPY**