

**Plano Independent School District
CANCELLATION REQUEST FORM**

Employee Name _____

Employee ID # _____

Please cancel the following plans:

- Employee Life Insurance
↳ also cancels any dependent life insurance
- Dependent Life Insurance only (*employee life insurance will remain active*)
- Disability Insurance

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I have been provided enrollment materials and policies, and I accept the coverage and limitations of the plans. I understand that I may re-apply for life insurance at any time, subject to policy provisions. I understand that I may not reapply for disability insurance until the next open enrollment period.

Employee Signature

Date Signed

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Benefits Office Use Only **Effective Date of Cancellation** _____

Pay Group: Monthly FacSrv FANS Transp PASAR Subs

Life Insurance: TEAMS _____
Adjust Payment Schedule (if needed)
If dropping ineligible dependent, notify employee & send conversion option

Disability Insurance: TEAMS _____
Adjust Payment Schedule (if needed)