For Benefits Staff Use Only
Vol S T Disability Cancellation
Effective Date:
/ /

Voluntary Short-term Disability Insurance

CANCELLATION REQUEST FORM

Employee Name (please print): _____

Employee #: _____

Department & Division: _____

Work # or Daytime Phone: _____

Please cancel the following Voluntary Short-term Disability Policy effective as of:

_____ 01, 20___

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Please Note: Cancellation requests are made for the first of the following month. In order for the change to occur, your form MUST be received in Business Services-Employee Benefits at least two weeks prior to the first pay date of the month.

By signing this form, I acknowledge that if I re-apply for this Voluntary Short-term Disability policy in the future my application will go through Cigna's underwriting process for approval or denial. I authorize Marion County to cancel the above Voluntary Short-term Disability Insurance Policy.

Employee Signature: _____ Date: _____

PLEASE MAKE A COPY FOR YOUR RECORDS BEFORE SENDING YOUR FORM TO EMPLOYEE BENEFITS.

Employee Benefits' Sign-Off: _____ Date: _____