For Benefits Staff Use Only
Vol ST 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 Human Resources - 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 the New York Life's underwriting process for approval, and may be denied at that time.
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.

You may email completed forms to:
MCEmployeeBenefits@co.marion.or.us

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