MESQUITE ISD CANCELLATION REQUEST

NAME: _____   **SS#:** _____

CAMPUS: _____   **EMPLOYEE ID#:** _____

My signature below authorizes cancellation of the following indicated deductions. I understand payroll changes will be made the first of the following month <u>after</u> this request is received in the Benefits Office.

<u>403(b), ROTH 403(b), 457 or ROTH 457</u>

○ **Annuity or Mutual Funds (please state name of company here):** _____

○ **Lone Star 529 Plan**

<u>UNSHELTERED</u>

○ **Automobile/Homeowners Insurance → By Texas State law, we are not allowed to stop your payroll deduction for auto insurance unless you provide a copy of your new coverage. Please attach it to this form.**

☆ **Disability Insurance → Can only be cancelled during benefits annual enrollment period.**

○ **Fidelity Life Insurance → Complete a Fidelity Life Request for Service Form to cancel this benefit.**
     Note: If you have a legal spouse, your spouse is required to sign this form, as well.

☆ **ID Shield → Can only be cancelled within 31 days of a Section 125 Qualified Event or during Benefits annual enrollment period. (Additional paperwork must be completed in the Benefits Office.)**

☆ **Legal Insurance → Can only be cancelled within 31 days of a Section 125 Qualified Event or during Benefits annual enrollment period. (Additional paperwork must be completed in the Benefits Office.)**

○ **Term Life Insurance**

☆ **Texas Life Insurance → Contact Texas Life Customer Service (at 1-800-283-9233 ext. 6815) to cancel your policy. (Franchise # SM2443)**

○ **Other** _____

<u>TAX-SHELTERED</u>

Premiums for the plans listed below are paid through the Section 125 Cafeteria Program with tax-sheltered dollars. Since an extra form is required, you must come to the Benefits Office to cancel any of these benefits.

   ✓ **Health Insurance**

   ✓ **Dental Insurance**

   ✓ **Vision Insurance**

   ✓ **Accidental Death & Dismemberment Insurance**

   ✓ **Cancer Insurance**

   ✓ **GAP Plan Insurance**

   ✓ **Unreimbursed Medical Expense Account or Dependent Care Account**

   ✓ **Health Savings Account (HSA)**

Signature of MISD employee: _____   **Date:** _____

Please return this completed form to the Benefits Manager.

3/9/2017