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.

403(b), ROTH 403(b), 457 or ROTH 457

- o **Annuity or Mutual Funds (please state name of company here): _____**
- o **Lone Star 529 Plan**

UNSHELTERED

- o **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.**
- o **CHUBB – (Lifetime Benefit Term)**
- ● **Disability Insurance → Can only be cancelled during Benefits annual enrollment period.**
- o **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.)**
- o **Standard Benefits Enhancer Bundle – (Accident/Critical Illness)**
- o **Standard Term Life Insurance**
- ● **Texas Life Insurance → Contact Texas Life Customer Service (at 1-800-283-9233 ext. 6815) to cancel your policy. (Franchise # SM2443)**
- o **Other _____**

TAX-SHELTERED

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 (AD&D)**
- ✓ **Cancer Insurance**
- ✓ **GAP Plan Insurance / Hospital Indemnity Insurance**
- ✓ **Unreimbursed Medical Expense Account or Dependent Care Account (FSA)**
- ✓ **Health Savings Account (HSA)**

Signature of MISD employee: _____ Date: _____

Please return this completed form to the Benefits Manager.