

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 after this request is received in the Benefits Office.

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

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

UNSHELTERED

- 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.
- CHUBB – (Lifetime Benefit Term)
- 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.)
- Standard Benefits Enhancer Bundle – (Accident/Critical Illness)
- Standard Term Life Insurance
- Accidental Death & Dismemberment Insurance (AD&D)
- Texas Life Insurance → Contact Texas Life Customer Service (at 1-800-283-9233 ext. 6815) to cancel your policy. (Franchise # SM2443)
- 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
- ✓ 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.

