MONROE- GREGG SCHOOL DISTRICT
DENTAL & VISION CANCELLATION REQUEST FORM

EMPLOYEE NAME: ______________________________ DATE OF BIRTH: ____________________

Please cancel the following insurance coverage(s):

METLIFE DENTAL COVERAGE:

______ Employee- Only Dental Plan

______ Employee- Parent Dental Plan

______ Employee- Couple Dental Plan

______ Employee- Family Dental Plan

______ Dependent Coverage – Dependent Name to be Cancelled: _________________________

ANTHEM VISION COVERAGE:

______ Employee- Only Vision Plan

______ Employee- Parent Vision Plan

______ Employee- Couple Vision Plan

______ Employee- Family Vision Plan

______ Dependent Coverage – Dependent Name to be Cancelled: _________________________

TO BE EFFECTIVE ON (provide date): _____________________

- *The earliest indicated coverage can be cancelled is at the end of the month in which this request is received in our office. Premiums must be paid through the cancellation date.*
- *Once cancelled, coverage will not be reinstated unless you meet a qualifying event.*

EMPLOYEE SIGNATURE: _____________________________ DATE: _________________________

Please return the completed form to the Administration Office.

Attn: Human Resources Coordinator
135 S. Chestnut Street, Monrovia, IN 46157
(317) 996.3720