Post-Tax Plan Cancellation Form

Lubbock ISD
Every Child Every Day

Effective date_____

Reason for Change:

Explanation Field:

Please Print:
Name of Employee: _____ ID# _____

Home Address:_____City:_____ State: ____ Zip:_____

Sex: Male ☐ Female ☐ **Date of Birth:_____**

Building or Organization:_____ Position:_____

Type of Coverage:	☐ **Life insurance** ☐ **Other Post-Tax Benefit** ☐ **Disability Coverage**

Company/Plan Name	Premium Amount
	$
	$
	$
	$
	$
	$

This form not applicable for pre-tax deductions.
****If this change is received after the current month's payroll has run then the change will occur on the following pay period.**

Signature: _____ **Date:** _____
I authorize the changes reflected on this form.

Revised November, 2020