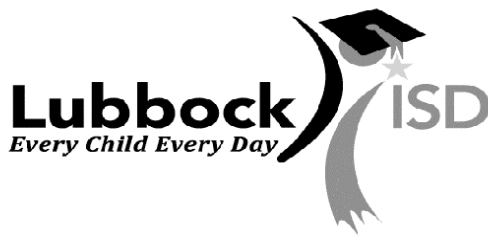


# Post-Tax Plan Cancellation Form



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: \_\_\_\_\_

<b>Type of Coverage:</b>	<input type="checkbox"/> Life insurance <input type="checkbox"/> Other Post-Tax Benefit <input type="checkbox"/> Disability Coverage
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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.**