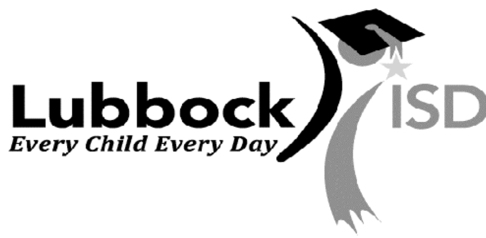
Post-Tax Plan Cancellation Form



Effective date______________

Reason for Change:

Explanation Field: Cancellation of insurance with New York Life. (List the name of each insured to be canceled.)

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**

☐ **Disability Coverage**

☐ **Other Post-Tax Benefit**

Send the completed form to:

vaun.murphrey@lubbockisd.org or fax to 806-766-1195

Company/Plan Name/Insured's Name	Premium Amount
New York Life -	$
New York Life -	$
New York Life -	$
New York Life -	$
New York Life -	$
New York Life -	$

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 October, 2018