BENEFITS CANCEL STATEMENT—OPEN ENROLLMENT

Only complete if you want to cancel a currently active benefit.

NAME:_____ SOCIAL SECURITY #:_____

PLEASE **INITIAL** BY EACH BENEFIT THAT YOU ARE CANCELING DURING OPEN ENROLLMENT:

_____ DENTAL INSURANCE

_____ VISION INSURANCE

_____ SHORT TERM DISABILITY

_____ LONG TERM DISABILITY

_____ CRITICAL ILLNESS

_____ HOSPITAL

_____ ACCIDENT

_____ CANCER INSURANCE

_____ EMPLOYEE TERM LIFE INSURANCE

_____ DEPENDENT TERM LIFE INSURANCE: ☐ SPOUSE ☐ CHILD

_____ WHOLE LIFE/UNIVERSAL LIFE INSURANCE (UNUM)

HEALTH INSURANCE MUST BE CANCELED/DECLINED ONLINE AT WWW.MYSHBPGA.ADP.COM

I UNDERSTAND BY INITIALING BESIDE THE APPROPRIATE INSURANCE AND SIGNING BELOW THAT I ACKNOWLEDGE THAT I AM CANCELING MY COVERAGE DURING OPEN ENROLLMENT. I UNDERSTAND MY CURRENT COVERAGE WILL END DECEMBER 31, 2023.

_____ _____

SIGNATURE DATE