

TERMINATION OF BENEFIT FORM

Name

SSN/EID

Please discontinue the payroll deduction from my pay for:

- | | | |
|---|--|--|
| <input type="checkbox"/> Health Insurance | <input type="checkbox"/> Life Insurance | <input type="checkbox"/> Long-Term Disability |
| <input type="checkbox"/> Dental Insurance | <input type="checkbox"/> Spouse Life Insurance | <input type="checkbox"/> Short-Term Disability |
| <input type="checkbox"/> Vision Insurance | <input type="checkbox"/> Premium Conversion (Pre-tax) | <input type="checkbox"/> United Way |
| <input type="checkbox"/> Savings Bond | <input type="checkbox"/> Fitness Center: <input type="checkbox"/> Employee Only; <input type="checkbox"/> Spouse Only; <input type="checkbox"/> Both | |

Effective Date: _____

Signature

Date