CANCELLATION NOTICE

Name: _____

Social Security # _____

District: _____ Campus: _____

Effective _____ payroll, I hereby cancel my premium deduction with respect to the following coverages and amounts:

INSURANCE COVERAGE

AMOUNT	TYPE OF COVERAGE	NAME OF INSURANCE COMPANY
$_____	Accidental Death/Dismemberment	_____
$_____	Cancer coverage	_____
$_____	Dental coverage	_____
$_____	Disability coverage	_____
$_____	Life coverage	_____
$_____	Medical coverage	_____
$_____	_____	_____
$_____	_____	_____

NON-INSURED COVERAGE

AMOUNT	TYPE OF COVERAGE	NAME OF INSURANCE COMPANY
$_____	Medical expense reimbursement	_____
$_____	Dependent care assistance	_____
$_____	Tax Sheltered Annuity (403B)	_____
$_____	_____	_____
$_____	_____	_____

My premium deductions shall remain in effect as to any coverages, which are not checked above.

_____ _____

Employee's Signature Date