



North East Independent School District

Insurance Cancellation

Name _____ Emp.ID # _____

Campus/Location _____ Monthly _____ Biweekly _____
(Please CHECK one.)

I hereby request the following insurance coverage to be cancelled*.

- Group Term Life Insurance - **Employee** (Standard Life Insurance Company)
- Group Term Life Insurance - **Spouse** (Standard Life Insurance Company)
- Group Term Life Insurance - **Child** (Standard Life Insurance Company)
- Disability/Income Replacement (Standard)
- Critical Illness - **Employee** (Standard)
- Critical Illness - **Spouse** (Standard)
- Critical Illness - **Child** (Standard)

* The effective date will be the last day of the month in which the NEISD Employee Benefits office receives this completed document. Documents received on a holiday or weekend will be received, and date stamped, the next business day.

Employee Signature

Date

For Office Use Only:

Change Effective _____ Approval _____ Date Processed _____