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** (Met Life)
- ☐ Critical Illness - **Spouse** (Met Life)
- ☐ Critical Illness - **Child** (Met Life)

* 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 _____

Revised 8/2026 JAM