Human Resources / Employee Benefits
15600 Concord Circle, Morgan Hill, CA 95037
Office: (408) 201-6019 fax: (408) 201-6026

Benefit Cancellation Form

Employee Information		
First Name:	Middle Name:	Last Name:
Classification:	Job Title:	

Please cancel my _____ policy
(life insurance, disability, etc.)

through _____
(name of company such as American Fidelity, Delta, VSP, etc.)

effective _____ , _____
(last day of whichever month you choose, such as November 30th, December 31st, etc.) (year)

I understand that I will no longer have coverage for this policy as of _____
(first day without coverage)

I understand that Morgan Hill Unified School District (the District) highly recommends that all employees are enrolled in vision, dental, and medical plans for their health and welfare selections. In addition, I acknowledge that the District highly recommends that all employees have a disability policy, especially since California State Disability Insurance (SDI) is not available to all employees. I further understand that it is my responsibility to monitor my vacation and sick leave balances AND to read my union contract for a thorough understanding of allowed leaves of absences and how my pay might be affected.

I acknowledge and authorize my payroll deductions to be adjusted accordingly if needed. However, if I submit this request after the payroll period has ended and/or without following the guidelines by the company that issued the policy and/or the District, I may not be eligible for a refund (if any were to apply).

I acknowledge that a future reinstatement is not guaranteed to be approved at all or even at the same rate. Most policies can only be added during Open Enrollment and cancelling this policy does not reserve me the exclusive opportunity to have this same, similar, replacement, or different policy at a future date.

_____ _____
Employee's Printed Name and Signature Date