ALLEGHENY COUNTY BENEFITS CANCELLATION FORM

EMPLOYEE NAME	EMP. #	PHONE #	SSN

The benefits program has been explained to me and I wish to CANCEL participation in the following employee benefits plan(s) effective _____:

_____ Highmark PPO Blue (PPO)

_____ UPMC Health Plan (PPO)

_____United Concordia Dental

_____ Davis Vision

_____ Bonus Waiver

_____ Optional Life Insurance

_____Voluntary Employee Term Life

_____ Voluntary Spouse Term Life

_____ Voluntary Child Term Life

_____ Accidental Death & Dismemberment

_____ Long Term Disability

_____ Pre-Paid Legal

IF YOU WANT TO CANCEL COVERAGE FOR A <u>SPOUSE AND/OR DEPENDENT</u>, PLEASE COMPLETE THE FOLLOWING:

NAME	SOCIAL SECURITY NUMBER	COVERAGE TO BE CANCELLED

_____ _____

DATE **EMPLOYEE SIGNATURE**

PLEASE PROVIDE THE INFORMATION REQUESTED ABOVE AND RETURN FORM TO HR/BENEFITS, ROOM 920 CITY-COUNTY BUILDING.

Revised October 2017