EMPLOYEE BENEFIT CANCELLATION

Employee Name: ____

Employee Number: ____

Employee Group:

Teacher _____ Allied Specialists _____ Principals & Vice Principals _____

Exempt _____ CUPE 947 _____ CUPE 382 _____

TTOC ______

Please cancel the following benefit coverage:

_____ Extended Health (CUPE employees must complete PEBT Waiver of Coverage Form)

_____ Dental

_____ Basic Life (coverage is compulsory for CUPE, Exempt & PVP)

_____ Basic AD&D (coverage is compulsory for CUPE)

_____ Optional Life

_____ Optional AD&D

Requested Date of Cancellation: ____
The cancellation date is always the last day of a current month

Reason for Cancellation: ____

Signature: ____ Date: _____________________