Decatur County Board of Education

Discontinuation & Change Form

General Information

Last Name________________________First Name____________________Middle Initial ______

SSN # ________________________ Date of Birth ________________________

School/Work Location________________________Occupation ________________________

Contact Number________________________Cell Number ________________________

Dental

☐ I elect to Drop my existing Dental coverage. ☐ I elect to Change my existing Dental coverage from_________to _________

Vision

☐ I elect to Drop my existing Vision coverage. ☐ I elect to Change my existing Vision coverage from _________to_________

Short Term Disability (STD)

☐ I elect to Drop my existing STD insurance coverage. ☐ I elect to Change my STD insurance coverage from_______to _______

Long Term Disability (LTD)

☐ I elect to Drop my existing LTD insurance coverage.

Term Life

☐ I elect to Drop my existing Term Life coverage. ☐ I elect to Change my Life coverage from___________to ______________

AD&D

☐ I elect to Drop my existing AD&D insurance coverage. ☐ I elect to Change my AD&D coverage from_________to _________

Universal Life

☐ I elect to Drop my existing Universal Life coverage.

☐ I elect to Keep my Life Policy, but Stop Deductions

☐ I elect to Keep my Life Policy, but Change Deductions from ______________to ________________ **Monthly**

By signing this form, I authorize payroll changes for the selected benefits. I understand that completion of additional forms may be required to ensure the changes indicated on this form. ***I understand that I cannot enroll or make changes again until next Open Enrollment unless I have a Qualifying Event. I understand that if I do have a Qualifying Event, I have to request changes within 31 days of the date of the event.*** I certify that information in this form is complete and accurate to the best of my knowledge and belief.

Employee Signature________________________ **Date**________________________