

CANCELLATION OF COVERAGE REQUEST FORM
Disability / Income Insurance Plans 001 and/or 002

EMPLOYEE NAME: _____

SOCIAL SECURITY# _____ EMP ID# _____

At which dealership do you work? _____

Date of this request: _____

NOTE: Earliest effective date of change/s is 1st of each following month.

Note: This form does not apply to any other coverage than what is shown here.

Please check the coverage(s) that you are requesting to be canceled. Check all that apply.

Short Term Disability 001

Long Term Disability 002

Employee Signature: _____ Date: _____

>Please forward your completed request to Ancira Team Services* for approval.

*If you don't know how to get this form to "Team Services", your manager or the Accounting Department staff will be able to help you or you may call 210.558.5052 / 888.876.4344 or fax this to 210-699-0575.

HR OFFICE USE ONLY:

Received: _____ Approved by: _____

Payroll to process for effective CANCELLATION date of: _____

TO PAYROLL _____

Please process, attach SCREEN PRINT and return this to HR file.
