

UNIVERSITY OF TENNESSEE INSURANCE CANCELLATION REQUEST

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| Employee Name: _____ |
| Social Security Number: _____ |
| Responsible Account Number: _____ |
| Paycycle: Monthly _____ Biweekly _____ |
| Effective Date of Cancellation: _____ |

Please Check the Type of Coverage to Be Cancelled

_____ Non-exempt Long-term Disability.

_____ Exempt Long-term Disability.

_____ Accident and Health Short Term Disability.

I hereby request cancellation of group insurance specified above. It is agreed that the acceptance of this notice shall constitute cancellation of the specified type of insurance coverage under Group Policy issued to my Employer by said Insurance Company; and, it is understood and agreed that effective on or after 12:01 a.m. of the last day of the insurance period in which this notice is signed, all insurance issued to me on behalf of the policy specified above shall cease and terminate. I further understand that if I choose to re-enroll in the specified program that is being cancelled, I must provide evidence of insurability in accordance to the policy rules and guidelines at my own expense.

Employee Signature

Date

To Be Completed By Insurance Officer

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| <i>Personnel Number of Employee:</i> _____ |
| <i>Insurance Officer:</i> _____ |
| <i>Date Request Received:</i> _____ |