

COMAL ISD
CHANGE/CANCELLATION FORM

NAME: _____ SS #: _____

CAMPUS: _____ PHONE #: _____

Effective with my _____ payroll, I hereby cancel/change my premium deduction with respect to the following coverage and amounts:

INSURANCE COVERGE

<u>Amount</u>	<u>Type of Coverage</u>	<u>Comments</u>
\$ _____	ALLSTATE CANCER	_____
\$ _____	UNUM DISABILITY	_____
\$ _____	SPECTERA VISION	_____
\$ _____	UNIMERICA GROUP LIFE	_____
\$ _____	TEXAS LIFE	_____
\$ _____	MEDICAL REIMBURSEMENT	_____
\$ _____	DEPENDENT CARE REIM.	_____
\$ _____	ORTHO ANNUAL REIM.	_____
\$ _____	_____	_____
\$ _____	_____	_____

My premium deductions shall remain in effect as to any coverages which are not checked above.

Employee's signature

Date