EMPLOYEE BENEFIT CANCELLATION

Employee Name: _____

Employee Number: _____

Employee Group:

Teacher ☐ Allied Specialists ☐ Principals & Vice Principals ☐

Exempt ☐ CUPE 947 ☐ CUPE 382 ☐

Teacher (TTOC) ☐

Please cancel the following benefit coverage:

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

☐ Dental (only district benefit for TTOC)

☐ 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: _____