# Supplemental Insurance Cancellation Form

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  UNLV Employee [ ]  CSN Employee [ ]  NSC Employee

Please cancel my deductions for the following supplemental products to be effective with my \_\_\_\_/\_\_\_\_/\_\_\_\_ paycheck.

### **PRE-TAX DEDUCTIONS**

**The following benefits were available on a pre-tax basis. If you elected to pre-tax this benefit, you must complete this form within 30 days of a qualifying event.**

**Buy-up Vision Plan Cancer Care Insurance**

[ ]  **VSP** [ ]  **American Fidelity**

**Personal Accident Insurance**

[ ]  **The Hartford AD&D**

### **POST-TAX DEDUCTIONS**

**Voluntary Life Insurance Short-Term Disability Insurance**

[ ]  **The Standard** [ ]  **The Standard**

**Automobile & Homeowner’s Insurance**

[ ]  **Liberty Mutual**

[ ]  **Traveler’s Insurance**

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please submit form to your campus Human Resources Office.**

**Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**