VOLUNTARY LONG TERM DISABILITY
WAIVE/CANCEL COVERAGE FORM

Team Member: _____

Personnel Number: _____

Location: _____

☐ I elect to waive participation in the Voluntary Long Term Disability Plan. I understand that I can apply for coverage during the next open enrollment period, however coverage is not guaranteed. In order to do so, I understand that I will be required to submit evidence of good health and be approved by the life insurance carrier.

☐ I elect to cancel my current participation in the Voluntary Long Term Disability Plan. I understand that this change in election will be effective beginning with the next payroll period following the date this form is signed and submitted to the Benefits Department.

_____ _____

Team Member Signature Date