



Date: _____

Please cancel Health: _____ Vision: _____ Dental: _____

United Health Care

Number of insured dependents:

Employee status:

Employee Only: _____ Employee + 1: _____ Family : _____ Dependents

New Bi-weekly deduction \$ _____ This will begin the pay period that includes _____.

Please make the cancellation effective _____.

Print Name: _____ Signature: _____

Witness: _____

Put effective date on Re-cap sheet to change in HR _____

Revise Insurance Census _____

Notify Teresa of change _____

Verify status change on invoice, in HR and on Census if status changed _____