INSURANCE CANCELLATION FORM

I AUTHORIZE THE CENTRAL CONSOLIDATED SCHOOL DISTRICT TO CANCEL MY DEDUCTION

TO _____ FOR MY _____
COMPANY TYPE OF INSURANCE

WHICH HAS BEEN IN THE AMOUNT OF $_____. THIS CANCELLATION IS TO BECOME EFFECTIVE WITH THE _____ PAY PERIOD.

NAME: _____

SIGNATURE: _____

DATE: _____

ID NUMBER: _____