

ALLEGHENY COUNTY EMPLOYEE BENEFITS

BENEFIT CANCELLATION FORM

EMPLOYEE NAME	DEPT.	EMP. #	UNIT I.D.	SOC. SEC. #
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The benefits program has been explained to me and I wish to CANCEL participation in the following employee benefits plans:

- | | |
|------------------------------------|---------------------------------------|
| _____ Highmark PPOBlue (PPO) | _____ Life Insurance (Employee Paid) |
| _____ United Concordia FLEX (PPO) | _____ Life Insurance (County Paid) |
| _____ United Concordia PLUS (DHMO) | _____ Voluntary Term Life Plan |
| _____ Bonus Waiver | _____ Accidental Death Insurance Plan |
| | _____ Voluntary Disability |
| | _____ Pre-Paid Legal |

IF YOU WANT TO CANCEL COVERAGE FOR A SPOUSE AND/OR DEPENDENT, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW AND RETURN FORM TO HR/BENEFITS, ROOM 102 COUNTY OFFICE BUILDING.

NAME	SOCIAL SECURITY NUMBER	COVERAGE TO BE CANCELLED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DATE

EMPLOYEE SIGNATURE