West Virginia University Division of Human Resources – Benefits Administration
PO Box 6640 ● One Waterfront Place● Morgantown, WV 26506 ● Phone: (304) 293-5700 x 4 ● Fax: (304) 293-7532

GROUP LONG-TERM DISABILITY PLAN COVERAGE CANCELLATION FORM

Should you have questions or concerns while completing this form, please contact a member of the Benefits Office at the number listed above.

Please Print:

Employee Name: Last, First MI	Email:
Employee Assignment #	Phone:

I hereby request that my coverage for long-term disability under the West Virginia University Group Long-Term Disability Plan underwritten by Standard Insurance be cancelled.

I understand that my coverage will end the first of the month following the receipt of this request by West Virginia University Division of Human Resources Benefits Administration. I also understand that should I wish to re-enroll in this plan, I may be required to complete and submit an Evidence of Insurability form or face other restrictions or be totally precluded for other reasons.

____________________________________ __________

Employee Signature Date

Once completed, please return this form to the address listed above.

Central Human Resources Use Only

Date of Final Deduction: __________

Completed by: ________________________________ Date: __________