NAPA VALLEY COLLEGE
Office of Human Resources, Training & Development

VOLUNTARY BENEFIT CANCELLATION REQUEST FORM

EMPLOYEE NAME: ______________________________________ **EMPLOYEE ID#**: ________________

I authorize the cancellation of the following voluntary insurance plan(s):

☐ Life Insurance: ____
☐ Employee *Name of Company*
☐ Dependent

☐ Disability Insurance: ____
☐ Employee *Name of Company*
☐ Dependent

☐ American Fidelity Cancer Insurance
☐ Employee
☐ Dependent

☐ American Fidelity Accident Insurance
☐ Employee
☐ Dependent

☐ American Fidelity Hospital Indemnity Insurance
☐ Employee
☐ Dependent

☐ American Fidelity Term/Whole Life Insurance
☐ Employee
☐ Dependent

☐ Miscellaneous: ____
☐ Employee *Type / Name of Company*
☐ Dependent

____ ____________________
Signature Date

IMPORTANT: All changes must be submitted by the tenth of the month to be reflected on the end of the month payroll.