UNIVERSITY OF LOUISVILLE

Voluntary Benefit Cancellation Form

Name: _____ **Employee ID:** _____ **Social Security Number:** _____

Home Mailing Address:
Street: _____ Apartment: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Pay Frequency: □ Monthly □ Biweekly

STEP 1: Please complete the appropriate section(s) below.	
□ Enrollment Cancellation Request I understand premiums following my cancellation request remitted to the carrier will be refunded directly to me by the carrier. I further understand once benefit has been cancelled, I may re-elect benefit and other benefits offered by the carrier during the next voluntary benefit enrollment period. I furthermore understand future benefit re-election may require proof of eligibility, in which additional underwriting may be required for policy issuance by the carrier.	Check all that apply: □ Long Term Disability Supplemental/Buy-Up **Must be full-time, earn $100,000 or more per year, participate in the University's Retirement Plan and receiving employer contributions.** □ Additional Life

By signing below, I agree the information provided on this form is true and correct to best of my knowledge.

STEP 2:	**Signature:** _____ **Date:** _____	
STEP 3:	Submit completed Voluntary Benefit Cancellation Form: **University of Louisville** **Human Resources** **215 Central Ave Ste. 205** **Louisville, KY 40208-2730**	**For questions email Benefits at benefits@louisville.edu or call (502) 852-6258.**