Date: ____________________________

FROM Name: ____

Address: ____

____

Telephone: ____

Email: ____

I wish to cancel my insurance benefits with Allstaff Payroll effective the 1st day of __________________.
(The next Month)

Select all that apply:

_______ Health _______ Dental _______ Vision

_______ Accident _______ Short Term _______ Cancer

_______ Hospital _______ Critical Care _______ Life

The following qualifying event(s) apply to me, which allows me to make changes outside of Open Enrollment.

_______ Birth _______ Adoption _______ Marriage

_______ Gain of Eligibility for Medicaid or CHIP Premium Assistance Program

_______ Change in employment status – full time to part time

_______ Reduction of hours with loss of eligibility

_______ Change in insurance coverage under other employer plan

_______ Loss of coverage sponsored by governmental or educational institutions

_______ Judgements, Orders, or Decrees

_______ Medicare or Medicaid entitlement

_______ Healthcare.gov Exchange enrollment

I affirm that I qualify to make changes outside of open enrollment based on my qualifying event and that I may require proof of said qualifying event to complete the process.

____ Date: _____________________

Signature of Employee/Member

____ Date: _____________________

Signature of Insurance Representative