SHORT TERM DISABILITY Discontinue DEDUCTION Lee County Board of County Commissioners

Name (Last, First, MI):		SS#: xxx-xx
Effective Date of Coverage:		Dept. /Entity:
Please complete this form		
	Lwould like to discontinue	enrollment in the Short Term Disability benefit.
	I would like to discontinue e	enfoliment in the Short Term Disability benefit.
Descrett D	advetian Avtherization	
Payroll Deduction Authorization		
I authorize my Short Term Disability premium deduction to be discontinued from my paycheck. I understand I can only terminate my participation in this plan during Open Enrollment my coverage will terminate as of December 31 st .		
By signing this agreement, I understand all aspects of this plan as they have been presented to me, and agree to all terms of this policy.		
If I choice to drop this plan, I will be required to submit an Evidence of Insurability (EOI) form in order to participate in the plan in the future. Note: This determination is made solely at the discretion of the provider.		
	e Signature ::	Date: