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

☐ I would like to discontinue enrollment in the Short Term Disability benefit.

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 31st.

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.

Employee Signature
Signature: _____ Date: _____