Lee County
Human Resources

SHORT TERM DISABILITY
DROP FORM
Lee County Board of County Commissioners

Name (Last, First, MI):_____ SS#: _____

Date of Birth: _____ Annual Salary: $_____

Effective Date of Coverage: _____ Dept./Entity:_____

Position Title: _____ Regularly Scheduled Work Hours Per Week: _____

Please complete this form in its entirety

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

Employee Signature

I understand that by dropping this plan, I will be subject to a review of Evidence of Insurability, and that a physical examination may be required in order to regain participation. Note: This determination is made solely at the discretion of the provider.

Signature:_____ Date: _____