CITY OF SPRINGFIELD, OREGON

HUMAN RESOURCES DEPARTMENT

Cancelation of Short-Term Disability (STD) Insurance

Today's Date: _____
Benefit No Longer Effective Date: _____
(Date is the first of the month following the date of signature.)

Employee Information:	
Name:	Employee ID:
Date of Birth:	

Voluntary STD Insurance (Coverage amounts are based on earnings, your cost will change if your earnings change.)

☐ I elect to CANCEL my short term disability coverage.

Confirmation
I acknowledge that I have been given the opportunity to enroll in the Short-Term Disability (STD) insurance coverage offered by the City of Springfield. I understand and agree that by cancelling coverage now, if I later decide to re-enroll, I will be required to provide evidence of insurability that is satisfactory to our STD Insurance carrier and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by our disability insurance carrier.

_____ _____
Employee's Signature **Date**