INSURANCE/DEDUCTION CANCELLATION FORM

To: DeKalb County Board of Education
Payroll Department

From: _____
Employee Name (Please Print Full Name)

_____
Last 4 # of Social Security

Date: _____
Month/Day/Year

Deduction: _____
Insurance Company Name

Deduction: _____
Dollar Amount if Known

Please cancel the payroll deduction indicated above.

_____
Employee Signature

All changes need to be received at Central Office via fax 615.597.6326 at least 15 days prior to the pay date.

If the request cannot be honored due to the election of a pre-tax status the employee will be contacted by the Payroll Department.