Catoosa County Government
Payroll/Benefits Department
Payroll Deduction Cancellation

Employee's Name _____

Please cancel the following payroll deductions effective _____:
(Date)

(I understand that I must allow time for notification to insurance companies and payroll before the cancellation will become effective.)

Please enter full name of family members whose coverage is to be stopped.

United Health Care – *Health* Insurance on: _____

United Health Care – *Dental* Insurance on: _____

United Health Care – *Optional Life* Insurance on: _____

Ameritas – *Vision* Insurance on: _____

American United – *Short Term Disability* on: _____

American United – *Long Term Disability* on: _____

Bankers Fidelity - *Life* Insurance on: _____

Columbian/Farmers – *Life* Insurance on: _____

CSO/Philadelphia American – *Cancer* Insurance on: _____

Catoosa County - *Pension Plan* on: _____

Gebcorp - *Retirement Plan* on: _____

_____ _____

Date Employee's Signature