MESSA
Good health. Good business. Great schools.

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Request for Group Benefit Cancellation

This form must be completed by all employers with groups cancelling benefits.

Employer Information *(Please Print)*

Employer	School #	Federal Employer Identification #
Contact	Email	Phone ( )

Group Eligibility Information *(Please complete a separate form for each employee group)*

Employee Group (e.g., teachers): _____

☐ **Full-time** ☐ **Part-time — Number of hours** _____

Eligibility Rules (located on the Group Benefit Program Statement; e.g., 123A): _____

Job Title Changes: _____

Group Benefit Cancellation *(Cancellation for a total or partial group will be either the end of the current month if notification is received on or before the 15th or the last day of the following month if notification is received after the 15th.)*

Requested Effective Date: _____

Cancellation of: ☐ **Total Group** ☐ **Partial Group** ☐ **Privatization**

Cancelled Benefits: ☐ **All MESSA Benefits** ☐ **Product Choice** ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Negotiated Life** ☐ **Negotiated LTD** ☐ **Stand Alone Rx** ☐ **Negotiated Dependent Life** ☐ **OptionALL** (Section 125)

Are you Cancelling Variable Options (Supplemental Term Life, Optional Dependent Life, etc) ☐ **Yes** ☐ **No**

Reason for Cancellation: _____

_____

_____

New Carrier: _____

Comments: _____

_____

_____

_____ _____

Employer Authorized Signature | Date