Canadian Benefits
CONSULTING GROUP

2300 Yonge Street, Suite 3000
Toronto, ON M4P 1E4
Tel: 1-800-268-0285
Fax: 416-488-7774

LONG TERM DISABILITY - MANDATORY ENROLLMENT TERMINATION OF COVERAGE APPLICATION

CUPE LOCAL 4168 – POLICY 28641

BASIC PERSONAL DATA (MUST BE COMPLETED)

NAME _____ _____ _____ GENDER: F ☐ M ☐
LAST FIRST MIDDLE

ADDRESS _____

CITY _____

POSTAL CODE _____ PHONE _____ – _____

E-MAIL ADDRESS _____

EMPLOYEE NO. _____

BOARD _____

POLICY NO. _____

INDICATE MEMBERSHIP OF:

ADMINISTRATION ☐
CLERICAL ☐
TRADESPERSON ☐

OTHER_____

DATE OF BIRTH ____ ____ ____
MONTH DAY YEAR

DATE OF HIRE WITH BOARD ____ ____ ____
MONTH DAY YEAR

EFFECTIVE DATE ____ ____ ____
MONTH DAY YEAR

SPECIAL NOTE

A request for cancellation can only be approved by your federation and Plan Administrator. Coverage cannot be cancelled retroactively. Cancelling your long term disability insurance (LTD) coverage should only be done after serious consideration of potential consequences.

A written request to retire, which includes your intended retirement date, MUST accompany this form prior to approval of this termination request being granted.

A copy of my retirement notice is attached. ☐

I,_____, wish to terminate my LTD coverage effective____/____/____
(print full name) mm/ dd / yyyy

and hereby authorize the board to cease payroll deductions as applicable for the above LTD plan.

Note: If a request for cancellation is received by the 15th of a month, coverage will be cancelled on the 1st of the following month. If the request is received after the 15th of the month, coverage will be cancelled on the 1st of the 2nd month following receipt.

In recognition of the documentation attached, I waive all rights of benefit or redress against the LTD plan, or my federation, or its officers, should I become ill or disabled subsequent to the effective date of this termination request and prior to my retirement from the board. I further understand that if I wish to re-apply for LTD coverage in the future, I will be required to submit satisfactory proof of insurability at my own expense and subject to the insurance carrier's approval.

Date ___/ ___/ ___ _____
mm/dd/yyyy Signature