

TO: Business Affairs Office
Episcopal Church House
Mount St. Alban
Washington, DC 20016-5094

SUBJECT: Request for Cancellation of Insurance Coverage

DATE: _____

Please use this form to request the cancellation of an employee's insurance coverage. In the Diocese of Washington, notification to the Insurance Administrator is required at least 30 days prior to the last day of employment. This notification is important as it affects insurance benefits for which the congregation may be held accountable.

IMPORTANT INFORMATION:

Name of congregation: _____

Address of congregation: _____

Name of Insured employee: (The Rev) _____

Cancellation Due to: Employment terminated - As of: ___/___/___

Transferring to another parish- As of: ___/___/___

Other: _____ - As of: ___/___/___

Cancellation Effective Date: _____

*New employment position: _____

*New home address: _____

*New contact information: Tel: _____ Email: _____

* If applicable

Which of the following benefits are to be cancelled? :

____ Yes ____ No Health Insurance - **3 month Ext. of Benefits offered**

____ Yes ____ No Disability Insurance: IRP LTD

____ Yes ____ No Life Insurance (Lay employees only)

AUTHORIZATION/OFFICIALS SIGNATURE:

Name: _____

Position held in congregation: _____

Telephone/Email: _____

Please mail this completed form to the attention of Mary Manson at Church House, Mt. Saint Alban, Washington, DC 20016, or fax to the attention of Mary Manson at (202) 537-2385.