REQUEST TO CANCEL/CHANGE INSURANCE
VSP

Please cancel my Vision Insurance (VSP)

Effective: ________________

OR:

Please change my Vision Insurance (VSP)

Currently:	____Single	Change to:	___Single
	____Two-Party		___Two-Party
	____Family		___Family

Effective: _________________________

Name: ___________________________

SSN: _____________________________

____
Signature   Date

Please note that open enrollment occurs August and September of every year. You will not be eligible to re-enroll outside of open enrollment unless you have a change in family status or change/loss of other insurance coverage.

This form must be received in the Benefits Office at least ten (10) days before the beginning of the month you are requesting the cancellation to occur.

Received in Benefits Office: ____________
Faxed/sent notification to VSP: _________
Changed in MUNIS: ____________