FAIRFIELD PUBLIC SCHOOLS
501 King's Highway
Fairfield, CT 06825

REQUEST FORM TO TERMINATE INSURANCE COVERAGE

In order to remove you or your dependents from insurance coverage, you must fill out and return this form to the Fairfield Public Schools Insurance Department.

EMPLOYEE'S NAME: _____

EMPLOYEE/CUSTOMER ID: _____

ADDRESS: _____

TOWN: _____ STATE: _____ ZIP: _____

NAME(S) OF MEMBER(S) TO TERMINATE:	MEDICAL/ PRESCRIPTION	DENTAL	DATE OF TERMINATION*
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	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Termination date is always the last day of the month. Terminations must not be retroactive.

REASON FOR TERMINATION:

_____ _____

SIGNATURE DATE