VSP VISION CANCELLATION REQUEST FORM

NAME: _____

LAST 4 DIGITS OF SSN: _____

INSTITUTION: _____

EMAIL ADDRESS: _____

Please cancel my VSP Vision Coverage for the 2016 plan year.

My signature below authorizes TSU/Tennessee Board of Regents to cancel my VSP Vision coverage and corresponding payroll deductions effective December 31, 2015. I understand I cannot re-enroll in VSP Vision coverage for 12 months and re-enrollment must occur during an open enrollment period.

_____ _____

Employee Signature **Date**

Fax form to Pam Trent, Benefits Specialist t 615-963-5027 or scan/email to ptrent@tnstate.edu . Forms are due by 4:30 pm October 15, 2015.