EDINBURG CONSOLIDATED INDEPENDENT SCHOOL DISTRICT
REQUEST FOR CANCELLATION

EFFECTIVE DATE _____

☐ Bi-Weekly

☐ Monthly

EMPLOYEE NUMBER _____

EMPLOYEE NAME _____

CAMPUS/DEPT _____

List the name of the deduction you are requesting to cancel below

_____
ANNUITY

_____
DISABILITY INSURANCE

_____
LIFE INSURANCE

_____
OTHER/MISC

_____
OTHER/MISC

_____ _____
Signature Date

For Payroll Use Only

Deduction Code _____ Deduction Amount $ _____

Cafeteria Plan (Y) or (N)? _____