Franklin County Schools
Stop Deduction Form

Plan Year – September 1, 2023 through August 31, 2024

Employee Name: ________________________________

Social Security Number: xxx-xx-_______

I request the premium payroll deduction be cancelled for the following benefit(s) effective 9/01/2023:

Payroll Deducted Insurance Benefit	Employee Signature	Deduction Amount
Individual Aflac Accident		
Individual Aflac Cancer		
Individual Aflac Critical Illness		
Individual Aflac Disability		
Individual Aflac Hosp Indem		
Individual Aflac Intensive Care		
Individual Aflac Life		
Individual Aflac Sickness		
Other		
Other		

I understand that by signing this document, I am authorizing Franklin County Schools to stop payroll deductions. However, this does not *cancel* the policy. The policy will lapse as a result of non-payment of premium.

Employee Signature ________________________ Date ____________

Enroller Signature ________________________ Date ____________

Rev. 4-2023