Group Benefits from The Hartford

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

City of Springfield
STD cancellation Form

- **Effective date of cancellation:** ________________
  (date must be the end of the month, premiums are not pro-rated)

Information About You	
Employee Name:	**Employee ID:**
Date of Birth:	
Date of Hire:	
Position:	**Department:**

☐ I elect to **Cancel** my short term disability coverage.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

Signed______________________________________ Date______________________

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Help protect tomorrow.