



## Employee Life, AD&D and Disability Insurance Compensation Change or Cancel Benefit Form

The following form should be submitted if/when an employee's compensation changes or if an employee is terminated and the life insurance policy benefits need cancelled.

Employer/Church Account Number:	Name of Person Completing the Form:
Employer/Church Name:	Telephone Number:
Employer/Church Address:	Email Address:
Date Form Completed:	Effective Date:

			Clergy Only				
Member Name: <small>List employees who have a compensation change or need policy cancelled</small>	Last 4 of SSN:	Annual Salary (A)	Housing or Parsonage Allowance (B)	Social Security or Medicare Offset Total (C)	Total Annual Compensation (A + B + C)	Cancelling Policy? (yes/no)	If Cancel, Enter Termination Date

Please keep a copy of this form for your records and email to [helpdesk@churchbenefits.org](mailto:helpdesk@churchbenefits.org) to submit for processing.