Cast & Crew

Request to Terminate

ELECTIVE CALIFORNIA STATE DISABILITY

This form is for terminating elective California State Disability Insurance coverage under California Unemployment Insurance Code Section 702.6(a)(b).

1. Please print clearly.

2. Send this form to Cast & Crew via:

   EMAIL EmployeeHelpDesk@castandcrew.com;

   FAX (818) 742-6568;

   DELIVERY 2300 Empire Avenue, 5th floor, Burbank, CA 91504

   ATTN: Data Operations

3. Please allow for 2 weeks processing time. Deduction is not eligible for retroactive calculations.

EMPLOYEE NAME	LAST FOUR DIGITS OF SSN	DATE OF BIRTH

EMPLOYEE ADDRESS

CITY

STATE	ZIP CODE	PHONE

E-MAIL ADDRESS

BY COMPLETING THIS FORM I HEREBY REQUEST TO DISCONTINUE THE DEDUCTION FOR CALIFORNIA STATE DISABILITY INSURANCE PREMIUMS FROM MY PAYCHECKS.

EMPLOYEE SIGNATURE (Please sign, scan and return once completed)	DATE
X	