

Termination of Benefit Form



Febco Benefits Administration

Participant Information

Employer Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____ Birthday: _____

Type of Termination (Check One)

Retired, Date _____

Passed away, Date _____

Terminated, Date _____

Resigned, Date _____

Benefit Termination Date

Benefits End Date: _____ Card Shut off date: _____

Date of last payroll deduction: _____ Total Amount withheld from Check: \$ _____

Termination of Participation

In the event that a Participant ceases to be a Participant for any reason, the Participant's election under the Flexible benefits Plan relating to contributions for medical reimbursements shall terminate. Notwithstanding Section 3.3 hereof, the Participant (or his estate) shall be entitled to payment or reimbursement only for Qualifying Medical Care Expenses incurred prior to the close of the period covered by the Participant's last contribution under Section 5.2 and only if the Participant (or his estate) applies for such payment or reimbursement in accordance with Section 6.1 on or before the _____ th day after the employee's Termination date.

To make a change, you must notify FEBCO of the actual event date before the change can become effective. H/R, please note that admin fees are still charged on the participants, during the run out period above.

Employee Signature: _____ Date: _____

H/R Signature: _____ Date: _____

Fax this form to: (502) 695-9692

Febco Benefits Administration
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Frankfort, KY 40602