Employee Termination Notification

This form collects information to ensure accurate account balance and contribution reporting.

It is very important to notify ProBenefits as soon as possible to avoid any errors in reimbursement.

Please Submit Promptly to ProBenefits – Fax (877) 761-1850

Company/Organization: ____

Name of Participant: ______________________________ Social Security # : ______________________

Termination Date: ____/____/____ Date of Last Payroll Deduction: ____/____/____

1) Benefit Information - Please complete for all Pre-tax Plan coverages. *

Type of Coverage	Payroll Frequency	Employee contribution amt per pay period	*Total* Employee contributions withheld	Employer contribution amt per pay period	*Total* Employer contributions
Medical FSA		$	$	$	$
Dependent FSA		$	$	$	$
Health Insurance		$	$	$	$
Dental Insurance		$	$	$	$
		$	$	$	$
		$	$	$	$

* The "Total Employee contributions withheld" and "Total Employer contributions" should be the total amount of deductions that have been or will be withheld for the terminated employee.

2) Comments

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3) Certification by Employer Administrator

Signature ______________________________ Date ___/___/___

Printed Name ______________________________

ProBenefits

ProBenefits, Inc.

2640 Reynolda Road · Winston-Salem, NC 27106-3817 · (336) 761-1850 · (888) 722-8382 · Fax (877) 761-1850 · www.ProBenefits.com