



Termination of Employee

Employer Name: _____

Employee Name: _____

Social Security: _____ Birthdate: _____

Retired, Date _____

Passed away, Date _____

Terminated, Date _____

Resigned, 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.

Employee Signature: _____ Date: _____

H/R Signature: _____ Date: _____

If you have questions, feel free to call **Febco, Inc.** toll-free 1-800-489-1539.

Customer Service is available to assist you, Monday through Friday, 8:00 A.M. until 4:30 P.M., Eastern Time.

Please fax this form to: 502-695-9692