



First Benefit Administrators

HRA  
EMPLOYEE  
TERMINATION  
FORM

EMPLOYER NAME: \_\_\_\_\_

The employer ***MUST*** notify **FBA** ***IMMEDIATELY*** when a participant terminates employment or wishes to terminate their election from the plan. This should be done by phone/fax/email for immediate notice and then followed with this written form.  
Phone: 800.571.4144 Fax: 727.535.3977

DATE: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_

TERMINATION DATE: \_\_\_\_\_

AN EMPLOYEE HAS SIXTY (60) DAYS FROM TERMINATION DATE TO SUBMIT CLAIMS WITH A DATE OF SERVICE PRIOR TO THE TERMINATION DATE.

BENEFIT ELECTION NOT TERMINATED ABOVE WILL REMAIN IN EFFECT UNTIL THE PLAN YEAR ANNIVERSARY DATE.

YOU'RE SIGNATURE STATES THAT THE PARTICIPANT HAS BEEN INFORMED OF THEIR COBRA CONTINUATION RIGHTS  
  
(COMPLETED BY TERMINATING EMPLOYEE AND PAYROLL DEPARTMENT, AS AUTHORIZED)  
  
Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
  
Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mail Completed Forms to: **FIRST BENEFIT ADMINISTRATORS, INC**  
13080 Belcher Road South, Suite A Largo FL 33773  
Phone: 727.530.4144 ♦ Fax: 727.535.3977  
[www.firstbenefitadmin.com](http://www.firstbenefitadmin.com)