

THE EMPLOYEE BENEFIT SERVICE CENTER
BENEFIT PLAN TERMINATION AND ADDRESS CHANGE FORM

EMPLOYER NAME: _____

INSTRUCTIONS: COMPLETE ALL INFORMATION AND SIGN THE FORM

THIS ACTION IS TO TAKE EFFECT ON THE FOLLOWING DATE: _____ / _____ / _____

NAME OF EMPLOYEE: _____

PLAN EMPLOYEE'S SOCIAL NUMBER: _____ / _____ / _____

INDICATE THE ACTION TO TAKE BY PLACING "X" IN FRONT OF THE ACTIVITY SELECTED.

_____ **AVALON BENEFIT SERVICES, PLEASE TERMINATE THE PARTICIPANTS BELOW:**

_____ TERMINATE ONLY THE EMPLOYEE IF THERE IS SINGLE COVERAGE; OR,

_____ TERMINATE THE EMPLOYEE AND THE ENTIRE FAMILY; OR,

_____ TERMINATE ONLY THE FOLLOWING INDIVIDUAL DEPENDENTS:

NAME OF SPOUSE: _____ DOB: _____ / _____ / _____

NAME OF DEPENDENT: _____ DOB: _____ / _____ / _____

NAME OF DEPENDENT: _____ DOB: _____ / _____ / _____

NAME OF DEPENDENT: _____ DOB: _____ / _____ / _____

_____ **AVALON BENEFIT SERVICES, PLEASE CHANGE THE PARTICIPANT'S ADDRESS TO:**

NUMBER/STREET _____

CITY _____ STATE _____ ZIP _____

COMMENTS/INSTRUCTIONS:

EMPLOYER'S SIGNATURE/INITIALS _____ DATE _____ / _____ / _____

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