

INTEGRATED BENEFITS
ADMINISTRATION

Employee Termination or Addition Form

Employer Name: _____

Date of Termination: _____ Plan Type: HRA FSA Day Care
 Date of Hire: _____ (check those that apply)

Employee Name: _____ Social Security Number: _____

Home Address: _____ Home Phone Number: _____

City/State/ZIP: _____ Work Phone Number: _____

Date of Birth: _____

Effective Date: _____ Last Pay Period: _____ ENDING BALANCE: _____

Dependants:

<u>Social Security Number</u>	<u>NAME</u>	<u>D.O.B.</u>	<u>Gender</u>	<u>Relationship to you</u>
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Name of Group Contact Person: _____

Signature of Group Contact Person: _____

Today's Date: _____

Fax to:

INTEGRATED BENEFITS ADMINISTRATION
208-287-0311