

Health Reimbursement Arrangement

Notice of Termination

Employer Name: _____

Employee Name: _____

SS #: _____

Street Address 1: _____

Street Address 2: _____

City, State, Zip: _____

Date of Termination: _____

Final Payroll Deduction Date: _____

Date: _____

Signature

Printed Name: _____

Title: _____