Termination Notification Form

Employer:_____

Employee / Participant: _____

SSN or ID: _____

Address: _____

The above participant terminated employment as of _____.

1. Date of the last salary deductions: _____.

   Amount of last salary deduction for **Healthcare**: $_____.

   Amount of last salary deduction for **Daycare**: $_____.

   Amount of last salary deduction for **Transit / Parking:** $_____.

   Amount of last salary deduction for **Other** _____: $_____.

2. Did the employee elect to fully fund his or her Health account from the last paycheck?
   ☐ Yes ☐ No

   If Yes, list contribution amount: _____, and

3. Total withheld pre-tax for the plan year:
   a. For **Healthcare**: $_____.
   b. For **Daycare**: $_____.
   c. **Other**: _____ $_____

Plan Representative Signature: _____
Date: _____

Please send this completed form to:

Benefit Administration Company
Attn: Flex Department
PO Box 550
Seattle, WA 98111-0550
Fax 206-682-8016
Email: flexcs@baclink.com

BAC
Benefit Administration Company LLC