

# FLEX BENEFIT ADMINISTRATORS

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## Flexible Spending Account Termination Notice Form

Employer: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Coverage Termination Date: \_\_\_\_\_

*(Can be different from actual termination date)*

### Spending Accounts:

#### **Total Amount Deducted — Current Plan Year-to-Date**

Medical Reimbursement Plan: \_\_\_\_\_

Child/Elder Care Reimbursement Plan: \_\_\_\_\_

Final Flex Contribution Date: \_\_\_\_\_

If applicable, date Debit Card should be closed \_\_\_\_\_

Forms received by the 25th will be reflected on next month's statement.

Fax to Flex Benefit Administrators at (713) 460-3550