AVALON BENEFIT SERVICES, INC.

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:

____

____

____

EMLOYER'S SIGNATURE/INITIALS ________________________________ DATE _____/_____/_____

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