Discovery Benefits®
FSA • HSA • HRA • COBRA • Transportation

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 866-451-3245
PO Box 2926 • Fargo, ND 58108-2926
customerservice@discoverybenefits.com

Benefits Termination Form

*=Required Fields

Step 1: Company Information

*Group Name (Do not abbreviate)

*Group ID

Step 2: Participant Information

*Participant Name

*Employee ID

*Benefits Paid Through Date (mm/dd/yyyy)

_ _ _ - _ _ - _ _ _ _
*Social Security Number

Step 3: Termination Information

Please select only one.

	Termination of Employment	Please select if the participant is no longer employed with your company.
	Termination of Benefits	Please select if the participant is still employed, but is no longer eligible to receive benefits.

Spouse and/or Dependent(s) Name(s) (required for Certificates of Coverage)

	*Account Paid Through Date	*YTD Deduction Amount
Medical or Limited FSA		
Dependent Care		
Health Reimbursement Arrangement		
Health Savings Account		
Adoption Assistance		

COBRA: Employers with 20 or more employees may be required to notify covered employees and family members of their right to continue participating in the group health plan and the medical spending accounts on an after-tax basis up to 18 or 36 months, depending on the qualifying event.

HIPAA: In some cases, the Health Insurance Portability and Accountability Act requires that Certificates of Coverage be sent to employees and family members when participation in a medical spending account terminates.

Step 4: Employer Authorization

*Employer Signature

*Date