

Employment Change Notice Form

(Termination of Benefits)

The **Employment Change Notice Form** for termination of benefits is a critical document used to officially inform relevant parties about changes impacting an employee's benefit eligibility. This form ensures timely communication and proper processing of benefit terminations in compliance with company policies and legal requirements. Utilizing a clear and accurate sample helps streamline administrative procedures and reduce errors.

Employee Information

Employee Name:

Employee ID:

Department:

Position/Title:

Termination Details

Termination Effective Date:

Reason for Termination:

-- Select Reason --

If "Other", please specify:

Benefits to be Terminated

☐

Health Insurance

☐

Dental Insurance

☐

Vision Insurance

☐

Life Insurance

☐

Retirement Plan

☐

Other

If "Other", please specify:

Additional Comments/Instructions

Add any relevant information or special instructions here.

Authorization

Supervisor/Manager Name:

Supervisor/Manager Signature:

(Type or sign)

Date Signed:

Submit Notice

Note: Please submit this form to the Human Resources department immediately upon awareness of benefit termination to ensure compliance and timely processing.