



**Notice of Benefits Termination
(For Termination of Employee's Benefits Only)**

City/Town: _____

Complete this form to **promptly** report an employee's termination of benefits.

Employee Name : _____

Employee's Address: _____

Date of Qualifying Event*: _____

Type of Qualifying Event**: _____

*Date of Qualifying Event: ***last day worked.***

**Type of Qualifying Event: termination of employment; retirement; reduced hours; death.

ATTENTION: If the Qualifying Event is ***Termination, Resignation or Reduction in Hours***, please indicate if this was:

Voluntary by the employee

Or

Involuntary by the employee

Submitted by: _____
(City Clerk/Payroll Officer)

Date: _____

Send Completed Form to:
MMIA EB Program
PO Box 6669
Helena, MT 59602
Fax: 406-449-7440