



**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.

Keep in mind that an employee's coverage terminates at the end of the month in which they are actively employed regardless of payroll deductions.

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