

NOTICE OF TERMINATION

CITY OF _____ 401(A) AND (H) PLAN

TERMINATED PARTICIPANT DATA:

Participant Name	Social Security Number	Sex (M/F)
Street Address (or P.O. Box)	Birth Date	Hire Date
City/State/Zip		
Marital Status (check one) Married _____ (if married provide spouse's data below) Single _____		

ALLOCATION AND 401(H) AUTHORIZATION:

401(h) Retiree Medical Expenses _____ % To transfer all balances to 401(a) indicate 0%. If no percentage is indicated the default percentage of 25% will be used.

Your signature below indicates that this is the percentage of your total balance to be designated as 401(h) money (not to exceed 25%) and that you understand that this election is irrevocable.

SIGNATURE OF TERMINATED PARTICIPANT:

Date _____ Signature of Terminated Participant _____

SPOUSE'S DATA: (Complete if married, include address if different)

Name _____ Date of Birth _____
Social Security Number _____
Address: _____

Your spouse is eligible for reimbursement of medical expenses, as are your dependent children.