Allegiance℠ by Cigna Healthcare

NOTICE OF TERMINATION

Group Name	
Group #	

Employee Information

Employee Name	
SSN	
Termination Date	

Coverage that is ending

PLAN	YTD AMOUNT
Medical Spending FSA	
Day Care FSA	
Parking FSA	
Mass Transit FSA	
Premium Reimbursement	

Please mail/fax completed form to:

ALLEGIANCE BENEFIT PLAN MANAGEMENT
PO BOX 4346
MISSOULA MT 59806
FAX: 1-877-424-3539

or scan and upload to Allegiance at www.allegianceflexadvantage.com