



Dear Employee,

This form serves as a formal notification regarding the separation of your employment with University Health. We would like to inform you that the coverage for most of your benefits will cease on the last day of the month following your official termination date.

Should you be interested in continuing or converting any of your current benefits into an individual policy, kindly indicate which benefit by checking the appropriate box next to the benefit listed below:

- Trustmark Universal Life
- Guardian Supplemental Disability
- Aflac Cancer
- Aflac Supplemental/Dependent Life

Employee Name: \_\_\_\_\_

Please provide your complete home/ mailing address and personal contact details in the spaces provided:

Home/Mailing Address	Personal E-mail Address	Phone Number	EE ID Number

By signing below, you consent to the release of this form to Benefit Source for the purpose of obtaining additional information on how to continue or convert your selected benefits into an individual policy.

\_\_\_\_\_  
**Employee Signature** \_\_\_\_\_  
**Date**

**\*\*Human Resources Use Only\*\***

\_\_\_\_\_  
**HR Representative Initials**

\_\_\_\_\_  
**Last day of employment**