Termination Notice
FSL Voluntary
Major Medical Complement Plan

Group Name: ____

Select correct termination action:

- Employee Only ☐
- Employee and Spouse ☐
- Employee and Children ☐
- Employee & Family ☐

Employee Name: ____

Employee Social Security #: ______________________________________

Dependent Name(s): ____

Termination Date: ____

Reason for Termination:

____

Submitted by: ____

Date: ____________________

Please fax this notice to:

Allstate Workplace Division
(866) 428-2453