

United Benefits Group Coop Retirement Plan

Employee Termination Date and Address Verification Form

Please complete this form and remit to United Benefits Group each time a participant in the Coop Retirement Plan terminates employment with your organization or transfers to another participating employer within the Plan. Please send the completed form immediately after the participant terminates. The form may be faxed to United Benefits Group at 816-459-8750 or mailed to P.O. Box 169005, Kansas City, MO 64116-9005. Failure to promptly notify United Benefits Group of participant terminations may result in incorrect billings for employer/employee contributions and may cause a delay in getting benefit estimates and/or payments to these terminated participants.

Participant Information:

Participant Name: _____

Social Security No: _____

Address: _____

City, State, Zip: _____

Termination Date: _____

Marital Status: _____

Spouse's Date of Birth: _____
(if applicable)

Is this a transfer to another participating employer? Yes _____ No _____

If yes, please fill out the "Notification of Employee Transfer In or Out" form, which can be found on our website www.co-opretirementplan.com, and fax with this form.

Employer Statement:

The above participant's employment terminated on the date indicated above. Both employee and employer contributions for this participant will be made in accordance with the contribution rules of the Co-op Retirement Plan.

Employer: _____

Group No: _____

City, State: _____

Authorized Signer: _____

Title: _____

Date: _____