To: FBMC Commonwealth of Virginia Processor
From: Agency Number:
Phone: Agency Name:

FBMC Benefits Administration Department
Please fax form to 850-514-5803

Employee Name: ____________________________ Employee ID#: _______________________

These changes apply to (check applicable box):

- [ ] 403(b) Contributions
- [ ] Post-Tax products
- [ ] Both

• Monies Expected - None Received:
  - [ ] Employee separated from state service (terminated, resigned, retired). Benefit End Date: ________________
  - [ ] Employee is on “Leave Without Pay”.
    Effective Date of Leave: ____________________________ Expected Return Date: ____________________________
  - [ ] Employee transferred to another agency.
    New Agency Number and Name: _________________________________________________________________
    Effective date of transfer: ____________________________
    Other: ______________________________________________________________________________________

• Monies Received - None Expected:
  - [ ] SRA and /or Cash Match form attached.
  - [ ] SDA form attached.
  - [ ] Other: ______________________________________________________________________________________

- [ ] Post-Tax - Employee Cancelled (Benefit) ____________________________ Benefit End Date: ________________
- [ ] Pre-Tax - SRA form attached cancelling deduction.
- [ ] Employee changed or added a benefit. SDA, SRA and/or Cash Match form attached, as appropriate.
  - [ ] Other: ______________________________________________________________________________________

FBMC/EDR-VDOA/1118