

LIBERTY LIFE ASSURANCE COMPANY OF BOSTON

A Member of the Liberty Mutual Group

NORTH CAROLINA STATE UNIVERSITY

DISABILITY EMPLOYEE TERMINATION FORM

Please type or print legibly

Employer Section			
1	<u>850-279590</u>	<u>North Carolina State University</u>	
	Group Policy No.	Employer Name	
2	_____	_____	_____
	Location Name	ID #	Dept # Class
3	COVERAGE TERMINATION DATE (If employee is terminating employment with NC State, please list date below.) _____		
	Date of TERMINATION OF EMPLOYMENT (Complete only if applicable.) _____		
Employee Section			
4	_____	_____	
	Employee Name	Date of Birth	
5	_____		
	Employee SS#		
6	_____		
	Street Address (Home)		
7	_____	_____	_____
	City	State	Zip Code
8.	I Authorize Liberty to make all changes indicated above. I declare all information provided is true and accurate.		
	_____	_____	
	Signature	Date	
<u>Please mail to the following:</u>			
North Carolina State University			
University Benefits Dept.			
Campus Box 7215			
Raleigh, NC 27695-7215			
			Rev. 9-19-01