TERMINATION FORM

DATE: _____

REQUEST TERMINATION DATE: _____

CARDHOLDER NAME: _____

LAST EIGHT#s OF CARDHOLDER ACCOUNT#(S): _____

OFFICE NAME (Include Office Symbol): _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

REASON FOR TERMINATION:

☐ PCS'd ☐ MOVED TO ANOTHER UNIT

☐ ETS'd ☐ OTHER _____

NOTE: Billing Officials will confirm that the actual cards assigned to these individuals were returned and destroyed.

BILLING OFFICIAL PRINTED NAME: _____

SIGNATURE OF BILLING OFFICIAL: _____