

FLEXIBLE SPENDING ACCOUNT

Employee COBRA Notice & Election Form

Today's Date _____

Employee Name _____

Employer _____

Employee Mailing Address, City, State, Zip Code _____

Social Security Number _____

Personal Phone Number _____

Email Address _____

This is to inform you that although you can no longer be covered under our Unreimbursed Medical Expense Reimbursement Plan, as of _____, you may continue your benefits under the plan beyond this date for the remainder of the plan year provided you have balance in your account (contributions are more than claims paid) at the time of your qualifying event. If any dependent of yours was covered under the plan, you may also continue their benefits.

You have 60 days from the date of this notice to notify us of your election.

If you elect this option, the benefits will be continued until:

- The end of the plan year following: _____;
- You become a covered employee under any group health plan that has no limitations or exclusions with respect to any preexisting conditions that you (or your dependent) may have;
- You or your dependent(s) become entitled to Medicare. If you become entitled to Medicare, the continuation coverage period for you dependent(s) begins on the date on which you become entitled to Medicare (or, if applicable, the date of an earlier qualifying event) and extends until the end of the plan year;
- You fail to pay the monthly charge for this coverage on time; or
- Our Unreimbursed Medical Expense plan is no longer in force; whichever event is earliest.

Before termination of employment, you had elected \$_____ of annual healthcare reimbursement benefits, for which you were contributing \$_____ (healthcare) per pay period through a payroll deduction. You and each of your dependents separately have the right to continue the listed annual healthcare reimbursement benefit(s) by continuing to pay for this coverage. If you elect to continue coverage a single monthly payment of \$_____ (includes a \$_____ service fee charge) will be required, and will cover you and your dependents. The initial premium payment will be for the coverage period from the date coverage as an employee terminates to the date you sign this election form or the plan year end, whichever is earliest.

We must receive your first payment within 45 days of the date you sign this election form.

Monthly payments are due on the first day of the month. If your first payment, or any subsequent monthly payment, is not received on time, you will lose your option to continue coverage. You have a 30-day grace period in which to pay premiums due.

Please complete the bottom portion of this notice. Keep a copy for your records and return the original copy along with your first payment to:

Total Payment Enclosed: \$ _____

Signature _____

Date _____

IMPORTANT: In order that your coverage may continue, we must receive:

- A completed copy of this notice by _____
- Your first payment within 45 days following the date you sign this form