ELECTION FOR CONTINUATION COVERAGE OF THE HEALTH FLEXIBLE SPENDING ARRANGEMENT

CONDITIONS AND REQUIREMENTS

Under Federal law, when coverage under a Health Flexible Spending Arrangement terminates due to a reduction in work hours or termination of employment, other than from gross misconduct, the law permits continuation of coverage under the Health Flexible Spending Arrangement for certain participants. A spouse or child of a participant who loses coverage due to the participant's death, divorce, legal separation or entitlement to Medicare or a participant's child who loses dependent status under the plan has the same rights to continue coverage as the participant. Any of the aforementioned individuals will be entitled to continue coverage under the Health Flexible Spending Arrangement for the remainder of the plan year in which one of the described events occurs if at the time the event occurs, the participant has made more contributions to the Health Flexible Spending Arrangement (including any contributions made on the participant's behalf by the employer) than they have received in reimbursements from the account.

Contributions to the Health Flexible Spending Arrangement for individuals choosing continuation coverage are the same as those for active employees. The Plan Sponsor may charge an additional two- percent of the contribution as an administrative fee.

In order to continue your coverage under the Health Flexible Spending Arrangement, you will be required to pay the full monthly contribution to the Plan Sponsor. Timely payment of the initial premium is 45 days after the election is made and every 30 days after that. The initial premium must cover all premiums due since the qualifying event. If subsequent premiums are not received within 30 days after their due date, rights to continuation coverage will expire and no coverage will be provided.

When an individual's coverage under the Health Flexible Spending Arrangement terminates, the Plan Sponsor must notify the individual, within fourteen days, of the right to continue coverage. This completed form must be returned to the Plan Sponsor within sixty days of notification. If it is not returned within that time, it is assumed the individual has elected not to continue under the Health Care Expense Reimbursement Account. Continuation coverage is not available after the sixty days have elapsed. The first monthly contribution must be paid forty five days from the date the individual signs this election form.

Continuation coverage will end on the first of the following events to occur:

(1) the end of the Plan Year in which the qualifying event occurred;
(2) the date the employer ceases to provide coverage under the Health Flexible Spending Arrangement to any employee;
(3) the expiration of the monthly period for which premiums have been paid, in the event of non-payment of premiums;

Please See Reverse Side For Election Form

ELECTION FOR CONTINUATION OF MEDICAL CARE EXPENSE REIMBURSEMENT ACCOUNT COVERAGE

To Be Completed By Employer

Plan Name:_____

Employee's Name: _____

Employee's SSN: _____

Employee's Mailing Address:

_____

(street)

_____

(apartment/ suite number)

_____

(city, state, zip code)

Mailing Date of this Notice: _____

Date of Qualifying Event:_____

Qualifying Event:

☐ Covered Employee's Death

☐ Covered Employee's Reduction in Work Hours or Termination of Employment *(provided it is not by reason of gross misconduct)*

☐ Covered Employee's Dependent Child Ceases to Be a Qualified Dependent

☐ Covered Employee Experiences Divorce or Legal Separation from a Qualified Beneficiary

☐ Covered Employee Becomes Entitled to Medicare Benefits Under the Social Security Act

Amount of Plan Year Benefits Remaining: _____ Plan Year Ending: _____

Mandatory Monthly Payment(s): _____ You must pay the required monthly payment for each month that has ended since your qualifying event at the time you return this notice. The payment must be sent within 45 days after the date you return this notice and subsequent monthly payments must be paid within 30 days of the first day of the month. Failure to make timely payments will result in your termination from the Plan.

Subsequent Monthly Payment: _____ (You may lower this amount but you must indicate the lower amount here: _____. Your Amount of Plan Year Benefits Remaining will be adjusted accordingly.

Payable to: _____

Address to Send Payments:_____

To Be Completed by Employee or Qualified Beneficiary

o I elect not to continue my coverage under the Health Flexible Spending Arrangement Plan.

o I elect to continue my coverage under the Health Flexible Spending Arrangement Plan and agree to the conditions and requirements outlined on the reverse side of this form.

Complete this section only if the applicant is a Qualified Beneficiary (rather than an ex-employee)

Qualified Beneficiary's Full Name: _____

Qualified Beneficiary's SSN: _____ Relationship to Participant:_____

Qualified Beneficiary's Mailing Address: _____
(street) (apt/suite)

_____
(city, state, zip)

Qualified Beneficiary's Date of Birth: ____/____/____

I understand the rules governing my continuation coverage and agree to advise the Plan Sponsor, in writing, in the event that I am no longer eligible for continuation of coverage or if I no longer wish to continue coverage.

_____

Employee or Qualified Beneficiary's Signature *Date*