



FLEXIBLE SPENDING HEALTH CARE REIMBURSEMENT ACCOUNT
COBRA ELECTION FORM

EMPLOYEE NAME: _____

COMPANY NAME: _____

SOCIAL SECURITY NUMBER: _____

TERMINATION DATE: _____

If you have a positive balance (payroll deductions are greater than the amount you have received in reimbursement) in your Flexible Spending Health Care Reimbursement Account at the time of termination, you may continue participation in the Plan for the remainder of the Plan Year. If you want to remain a participant in the Plan, you can do so by selecting one of the COBRA options below.

Please note that if you do not elect COBRA continuation, any balance in your account will be forfeited. You will have 90 days to submit claims for expenses incurred prior to your termination.

_____ COBRA CONTINUATION WITH PRE-TAX CONTRIBUTIONS
I elect COBRA for the Flexible Spending Health Care Reimbursement Account. The remaining contributions for the period indicated below (select one) will be deducted from my final paycheck.

Remainder of the Plan Year

Through the month of _____ (List month that you want COBRA coverage through)

_____ COBRA CONTINUATION AFTER-TAX CONTRIBUTIONS
I elect COBRA for the Flexible Spending Health Care Reimbursement Account and will pay you with after-tax dollars on a monthly basis.

EMPLOYEE SIGNATURE: _____ DATE: _____

Please submit this form to your Employer.