AMERICAN BENEFITS GROUP

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) CONTINUATION OF BENEFITS FORM

For Plan Year Benefit Election Change

Name: _____ Last Four Digits of SSN: _____

Employer: _____

This is to inform you that even though you will no longer be eligible to participate as an employee in the Section 125 Flexible Benefits Plan as of _____, 20_____, you and your dependents may continue your benefits under the FSA Plan beyond this date. If you chose to continue under the Plan, your claims will be processed until the first of these conditions is met:

a) You have received the full amount of your original annual election under the FSA as payment for expenses incurred;

b) The Plan Year ends (there is a ninety (90) day grace period after the Plan Year ends during which you may submit all eligible expenses incurred during the Plan Year);

c) You fail to remit your monthly payments on time; or

d) The FSA is no longer in force.

During the current Plan Year enrollment period, you elected an Annual FSA of $ _____, for which you have been contributing $_____ per pay period. You have the right to continue to use the full amount of your original Annual Election by continuing to make monthly after-tax contributions at the rate of 102% of the ANNUAL BALANCE DUE divided by the number of months remaining in the Plan Year.

Calculation of Annual Balance Due

ORIGINAL ANNUAL FSA ELECTION:			$_____ (A)
TO-DATE CONTRIBUTIONS:		**Number of Contributions**	
Per Payroll Contribution: $_____	x	Made to Date: _____	$_____ (B)
ANNUAL BALANCE DUE TO CONTINUE RECEIVING BENEFITS: (A) - (B)=			$_____ (C)

If you do not check "YES" below, you waive your option to continue coverage and any medical expenses incurred after your date of termination will not be eligible for reimbursement. You will have 90 days from your date of termination to submit claims for expenses incurred prior to your termination.

I HAVE READ THE ABOVE AND UNDERSTAND MY OPTIONS CONCERNING CONTINUATION IN THE MEDICAL EXPENSE REIMBURSEMENT PLAN. I HEREBY CHOOSE THE FOLLOWING OPTION: **(select one)**

☐ YES, I wish to continue my benefits under the Plan. I agree to make monthly payments at the rate of 102% of the ANNUAL BALANCE DUE divided by the number of months remaining in the Plan Year.

☐ NO, I DO NOT wish to continue my employee benefits under the Plan. I realize that by not continuing coverage under the Plan, any medical expenses incurred after my date of termination will not be eligible for reimbursement, even if I have funds remaining in my account.

Employee's Signature: _____ Date: _____

Fax Toll Free: 877-723-0147 or email to processing@amben.com

No Fax Machine? Mail to: American Benefits Group • P.O. Box 1209, Northampton, MA 01061-1209 • 800-499-3539