MidAmerica
Administrative & Retirement Solutions

FLEXIBLE SPENDING HEALTH CARE REIMBURSEMENT ACCOUNT AGREEMENT UPON TERMINATION

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 in the Plan, you can do so by selecting one of the COBRA options below. If you prefer to terminate your participation and contribution to the Plan, any balance in your account on your date of termination will be forfeited if expenses were not incurred prior to your date of termination.

_______ I elect to terminate participation in the Flexible Spending Health Care Reimbursement Account. I understand that I can submit claims for eligible medical expenses that were incurred prior to my termination. If I do not have sufficient claims that were incurred prior to my termination to exhaust my account balance, any unused balance will be forfeited.

_______ COBRA CONTINUATION WITH PRETAX 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.