FSA COBRA ELECTION / WAIVER FORM

TO BE COMPLETED BY EMPLOYER **DATE:**

Name of Employee:_____

Date of Last Day Worked: _____

Date Election Period Expires (60 days from the date of notice):_____

Monthly Premium for Continuation of FSA : _____

Name and Address of Employer:_____

Employer's Signature: _____

TO BE COMPLETED BY EMPLOYEE, DEPENDENT, OR LEGAL GUARDIAN

I, _____, as a former participant in the Employer sponsored Flexible Spending Account (FSA), have experienced a qualifying event as defined by the COBRA guidelines.

My signature at the bottom of this form represents my stated understanding of all rights and responsibilities as described in the COBRA information summary, to elect or reject the option to continue coverage through the group FSA plan of the Employer.

( ) I **do not** wish to continue coverage under COBRA
( ) I **do** wish to continue coverage under COBRA

1. Are you covered by any other group policy? ( ) Yes ( ) No

   Name of Company:_____

2. Current Home Address and Phone: _____

   _____

3. Identify Qualifying Event:_____
   Date of Occurrence: _____

All persons to be continued, including employee if applicable:

	Name	Social Security #	Relation	Birthdate
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

EMPLOYEE SIGNATURE _____

Consolidated Omnibus Budget Reconciliation Act

A federal law (Public Law 99-272, Title X, commonly known as COBRA) requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage"). This notice is intended to inform you of your rights and obligations under the law. You are advised to read this notice carefully.

QUALIFYING EVENTS:

- Reduction of scheduled work hours
- Termination of employment, for reasons other than gross misconduct
- Legal separation or divorce
- Death of employee
- Independent child ceasing to be eligible dependent

Under the law, the employee or family member has the responsibility to inform the Employer within 60 days of the occurrence of the qualifying event. When the Employer is notified of the qualifying event and the desire to elect continuation of coverage, you will be provided with an election/waiver form to complete. You have 60 days from the receipt of the form to return it to the Employer if you wish continued coverage. If you do not return the election/waiver form within 60 days, you will waive your right to participate and therefore your FSA coverage will end the first of the month following the date of your qualifying event.

If you elect to continue coverage you will be required to pay 100% of the premium at the group rate, plus a 2% administrative fee. Premiums are due starting the first of the month following any qualifying event. You have 45 days from the date you elect coverage to make your first premium payment along with payment for any prior months. If you do not send payment retroactive to the first of the month following your qualifying event and/or fail to comply with the specified time limit, no claims will be paid and coverage will not continue. Monthly premium payments will be due on the first of each month. **NO BILL WILL BE SENT.**

You may be eligible for continuation of coverage for 18 months, or an extension for 29 or 36 months depending on your qualifying event.

Coverage will continue according to the qualifying event, or until any of the following occur:

- The Employer ceases to provide any coverage to active eligible employees.
- You become covered under any other group FSA plan either through your employment or your spouse's employment (unless that plan does not cover pre-existing conditions).
- The premium for your COBRA coverage is not received by the first day of each month.

You may be eligible to extend your continuation of coverage if you experience another qualifying event during your initial continuation period. If you have any questions about your rights and responsibilities described in this summary, please call Vantage Flex, LLC at 906-863-3539. Participants electing to continue coverage through COBRA should make checks payable to _____and mail to:

Employer: _____
Address:_____
City/State/Zip:_____