

State of Delaware Flexible Spending Account

UNPAID LEAVE OF ABSENCE ELECTION FORM

Plan Year: _____

Date of Leave: _____

Employee Name: _____

Employee Id#: _____

Agency/School District: _____

Daytime Phone: _____

Benefit Representative: _____

The State of Delaware's plan permits a Health Flexible Spending Account (HFSA) participant the following options while on an unpaid leave of absence (LOA), under Internal Revenue Service regulations. You must elect one of the following options **prior** to beginning your LOA. You may not change the underlying HFSA election **amount** on account of commencing or returning from the LOA; this form addresses how you will pay for HFSA coverage.

FMLA Leave Non-FMLA Leave

Revoke – By choosing this option, I elect to revoke contributions to my HFSA during my LOA. I understand my period of coverage will end as of the first day of my LOA and that claims incurred after this date will not be eligible. I also understand that when I return to work, I may re-enter the plan with the same deductions elected before my LOA and that I must contact my plan administrator if I wish to do so. If you elect to revoke your HFSA and are on LOA less than 31 days, your election will automatically be reinstated upon your return and missed deductions will be collected from your paychecks on a pre-tax basis.

Catch-Up – By choosing this option, I understand that during my LOA, my employer has agreed to make contributions to my HFSA. I further understand that when I return to work, the amount of contributions my employer made on my behalf will be deducted from my paychecks on a pretax basis. I consider this amount a debt I owe my employer. I understand that my period of coverage will extend throughout the LOA and claims for expenses incurred during my LOA will be eligible for reimbursement.

If this form is not submitted before a LOA begins, participation in the HFSA will be revoked during the entire period of LOA and the HFSA will be subject to the provisions of a revoked account, as outlined above.

Employee Signature: _____

Date: _____

Return this form to your organization's Human Resources Office upon completion.

Please contact Statewide Benefits Office, (302) 739.8331 with questions or fax (302) 739.8339