

FLEXIBLE BENEFITS PLAN
SEPARATION FORM

For Plan Year Ending _____

NOTE TO EMPLOYEE: Use this for your final reimbursements and revocation or continuation of Benefits in the Plan Year during which you separate from service. If at the time of your separation you have any reimbursements or forfeitures outstanding for a previous Plan Year, please also complete a final Benefit Request Form for that year.

Full Name: _____ Soc. Sec. No: _____ - _____ - _____
(please print)

I state as follows:

1. **Receipt; Representations; Authorization; Etc.** I seek reimbursement for the following eligible expenses in accordance with the Plan. I haven't been paid by insurance or under this Plan or otherwise for any of the expenses reported in this form and no claim has been made or will be made to any insurance company or governmental agency for duplicate reimbursement. I authorize my Employer to make any inquiries it may deem fit regarding such expenses. A copy of this completed form shall serve as an original for all purposes. I am aware that my spouse, my dependents and I may have continuing health coverage under the Plan if we pay in 102% (or in some cases, 150%) of our election and elect under the Plan on a timely basis for the next Plan Year.
2. **My Promises to my Employer.** In the event there is any misstatement or miscalculation on this or any attached forms, or if my Employer makes an overreimbursement, I understand I'll be liable (1) for all taxes, penalty, and interest imposed upon either my Employer or myself by the IRS of any state or local revenue agencies with respect to any Benefits received by me, and (2) to repay my Employer for any overreimbursement. I represent that the total expenses for which I seek repayment on this form in each of the four categories of Dependent Care, Group-Term Life, Outside Health Insurance and Health Expenses, including prior reimbursements during the Plan Year, are no more than the amounts I've elected in each category for the Plan Year.
3. **Reimbursement.** I'm entitled to receive reimbursement of the amount of eligible expenses set out below. I've stapled to this form statements (or receipts) from independent third parties stating that the expenses for which I seek reimbursement have been incurred and their amounts.

A. <u>Dependent Care</u>	\$ _____
B1. <u>Group-Term Life Insurance</u>	_____
B2. <u>Outside Health Insurance</u>	_____
C. <u>Health FSA</u> (out of pocket medical)	_____
D. <u>Total</u>	\$ _____

4. **Revocation or Continuation of Elections.** For each category of non-payroll deduction expenses (Dependent Care, Group-Term Life, Outside Health Insurance and Health FSA Expenses) you have a choice between (a) revoking your election (i.e., ceasing salary reductions), or (b) continuing your election and paying the election amount not already deducted from your previous paychecks either out of your final paycheck, or by an after-tax payment to your employer. For each of the four categories, please complete *either* 4A, starting with the checkbox on Line 1, *or* 4B, starting with the checkbox on Line 4.

A. **Revocation of Elections.** I wish to revoke my elections (i.e., cease salary reductions) for the categories completed below (Lines 1, 2, and 3) effective the day I separate from service, and choose to receive only the balance set out on Line 3 for the remainder of the Plan Year. I understand if I return to service, I will not be permitted to make new Benefit elections in the present Plan Year. NOTE: If you revoke your elections, the Plan permits you to be reimbursed Dependent Care, Group-Term Life and Outside Health Insurance expenses (but not Health FSA expenses) incurred after separation from service only up to the amount deducted from your pay before separation.

	Dependent Care	Group-Term Life	Outside Health Ins.	Health FSA
<u>I revoke</u> (check box):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Year-to-date salary reductions	\$ _____	\$ _____	\$ _____	\$ _____
2. Expenses incurred this Plan Year <u>before</u> separation, Including those in paragraph 3 above.	_____	_____	_____	_____
3. Amount of expenses incurred <u>after</u> separation date for which I'm entitled to seek reimbursement.	\$ _____	\$ _____	\$ _____	Not reimbursable

B. **Continuation of Elections.** (Do not check any category previously checked in paragraph 4A above.) I wish to continue my election for each of the categories completed below (Lines 4, 5, 6 and 7).

	Dependent Care	Group-Term Life	Outside Health Ins.	Health FSA
<u>I continue</u> (check box):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Total Election for Plan Year	\$ _____	\$ _____	\$ _____	\$ _____
5. Less: Salary Reductions to date of separation	(_____)	(_____)	(_____)	(_____)
6. Any difference (4 less 5)	\$ _____	\$ _____	\$ _____	\$ _____
7. Amount in Line 6 funded by:				
a. Final pay reduction	_____	_____	_____	_____
b. After-tax payment	_____	_____	_____	_____

I declare the information furnished above is, to the best of my knowledge and belief, true, correct and complete.

Premiums paid through _____, 20____

X _____
Participant's Signature

Date: _____, 20____