



**Flexible Benefit Program Statement of Intent
Leave of Absence**

Employee: _____

SSN: _____

Today's Date: _____

Estimated Leave Date: _____

Estimated Return Date: _____

Flexible Spending Account(s):

Health Care Spending Account Annual Election: \$_____ Per Pay: \$_____

Dependent Care Spending Account Annual Election: \$_____ Per Pay: \$_____

Please select the option you wish to choose regarding the funding of your Flexible Spending Account(s):

I choose to cancel my Flexible Spending Account(s). I will have no other payroll deductions for my Spending Account, and I understand that I will not be eligible to participate in the plan until the next open enrollment period or change in status event. My last day of eligibility in the plan will be the final day I work prior to my leave of absence. Claims incurred after this date will not be eligible for reimbursement.

I choose to pre-fund my Flexible Spending Account(s) by having those premiums that will be missed while I am on leave of absence deducted from my pay (on a pre-tax basis) prior to my leave of absence. My annual election amount will not be adjusted, and I can submit claims for services incurred during my leave.

I choose to make up any missed premiums toward my Flexible Spending Account(s) when I return from my leave of absence (on a pre-tax basis). My annual election amount will not be adjusted, and I can submit claims for services incurred during my leave after I return to work.

I choose to pay my Flexible Spending Account(s) premiums on an after-tax basis while I am on leave of absence. My annual election amount will not be adjusted, and I can submit claims for services incurred during my leave.

Employee: _____

Date: _____

HR Dept.: _____

Date: _____