

Unpaid Leave (12 Week Maximum) Documentation

Please complete this form and forward with the List Bill for all employees that are interrupting or ceasing pre-tax contributions to a medical spending account or a dependent care assistance program due to an unpaid leave.

Employer Name: _____ Date: ____/____/____

Employee's Name: _____ Employee's SS#: _____

Leave Start Date: ____/____/____ Expected Leave Return Date: ____/____/____

Reason for Leave:

Medical Spending Account amount per pay period \$ _____
Dependent Care Assistance Program amount per pay period \$ _____

1. I elect to continue the benefits listed above while on unpaid leave

Method of reimbursement:

Early reimbursement through payroll deduction

After tax reimbursement during leave

Retroactive reimbursement through payroll deduction

Employee Signature _____ Date ____/____/____

2. I elect to revoke the benefits listed above while on unpaid leave

I understand that if I return from leave within 12 weeks, I may reinstate my benefit elections by either accelerating pre-tax payments to contribute the full year election amount, or by resuming pre-tax payment of previous per pay period amounts. I also understand that if I revoke benefits while on leave, I will not be eligible for reimbursement for claims incurred during the period for which benefits were revoked.

Employee Signature _____ Date ____/____/____