

TAI**Flexible Benefit Plan - Termination & COBRA HCRA****ONLINE***All Information Required - Print Clearly - Sign & Date Below***▶ EMPLOYER** _____

Employee _____ Social Security # _____

Home Address (Street) _____ Check
box if: New Address

City _____ State _____ Zip code _____

Daytime Phone () _____

E-Mail Address _____

PART I. DECLINE TO CONTINUE HEALTH CARE ACCOUNT

I do not wish to continue my health care reimbursement account under the Flex-Plan. I understand that I may be reimbursed for expenses incurred up to my termination date. To be eligible for reimbursement, I must file a claim within that Plan Year plus 90 days following the Plan Year end. I am aware that unclaimed amounts are forfeited.

PART II. ELECT TO CONTINUE HEALTH CARE ACCOUNT

It is understood that COBRA-Flex may be offered in cases where participants have a positive balance at the time of termination and does not extend beyond the current plan year unless my plan is exempt from HIPAA.

Accordingly, I wish to continue my health care reimbursement account under the Flex-Plan. I understand that I have 60 days from the date of my termination to notify my employer of my election to continue coverage. The first payment must be received by the employer within 45 days of my termination date. If the first payment, or any subsequent payment is not received on time, I will lose the option to continue coverage. I have a 30-day grace period in which to pay premiums pending timely receipt of the first premium payment. If I choose not to accept this COBRA-Flex Continuation Coverage, I will not be reimbursed for expenses incurred after my termination date. I may receive reimbursement for expenses incurred up to my termination date and file a claim within that plan year plus the grace period of 90 days; unclaimed amounts are forfeited.

Before termination, I had elected a total of \$ _____ in annual health care reimbursement benefits for the current Plan Year, for which I was contributing \$ _____ per month through salary reduction. To continue to receive reimbursements for incurred expenses, the required after-tax monthly cost is \$ _____ [same as prior amount plus employer may charge 2% of that amount].

Make check payable to your former Employer.

Completed by Employer

Payroll Effective Date: _____ Approved by H.R. Dept.: _____
[Start of New Deductions] [Signature or Initials]

▶ Employee Signature _____ **Date** _____**Routing:** Original to Employer's H.R. Dept. • Copies for Participant & TAI • Questions: 800-932-3539 • Fax: 510-451-8611