Section 125 Benefit
Termination From Service
Election Form

Employ**er** Name: Date:

Employ**ee** Name:

Termination From Service Date:

☐ **I understand that under COBRA I have the right to request that my Section 125 Unreimbursed Medical coverage be continued through the end of the Expense Period of the current Plan Year and I elect to do so.**

Total Contributions for Unreimbursed Medical Benefit (UMA) budgeted amount) Prior to Termination: $_____
Remaining Contributions to Reach Annual Target $_____
Number of Months Remaining in the Plan Year _____
Administration Fee (2% of remaining annual UMA budgeted amount) $_____

☐ I agree to pay, to my employer, my monthly Unreimbursed Medical Benefit contribution of **$ _____,** plus the $ _____ monthly Administration Fee on the first of each month through the end of the Plan Year in order to continue my Section 125 Unreimbursed Medical Account benefits.

-or-

☐ I elect to pre-pay my Unreimbursed Medical Account contribution on a pre-tax basis, from my final month's pay check(s) in order to continue my Section 125 Unreimbursed Medical Account benefits.

☐ **I do not want my Section 125 coverage continued to the end of the current Plan Year.**

I understand that I may seek reimbursement for only those unreimbursed medical expenses incurred within this Plan Year, but prior to my date of termination. I also understand that I have a 90 day grace period following my date of termination in which to submit my claims. Any funds remaining in my account after these reimbursements have been made will be forfeited to my employer.

☐ **I understand the following statement regarding my Dependent Day Care and/or Premium Expense Account(s)**

I will have $_____ in my Dependent Day Care Account by my date of termination. I may continue to draw on this balance, for employment related day care expenses only, until the end of the Plan Year. I will have $_____ in my Premium Expense Account by my date of termination. I may continue to draw on this balance until the end of the Expense Period of the current Plan Year.

Employ*ee* Signature: **Date:**

Employ*er* Signature: **Date:**

WHERE TO SEND COMPLETED FORM:

ORIGINAL COPY - File with Employ**er**
PHOTOCOPY - PG; P.O. Box 15136; Albany, NY 12212-5136 (FAX# 518-641-0325)

9/28/06