

**FLEXIBLE BENEFITS ACCOUNT
LEAVE OF ABSENCE UNDER FAMILY AND MEDICAL LEAVE ACT (FMLA)**

THIS FORM SHOULD ONLY BE COMPLETED IF EMPLOYEE IS GOING ON LEAVE OF ABSENCE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA).

Employee Name:		SSN:
Street Address:		City:
State:	Zip:	Date of Birth:

Effective Date of FMLA Leave: _____ Estimated Date of Return from FMLA Leave: _____

The following options are available and must be agreed upon by both Employee and Employer. A detailed description of all options are available in the Summary Plan Description under section titled "FLMA".

IF APPLICABLE, PLEASE SELECT ONE OPTION FOR EACH BENEFIT

Medical FSA

1. PRE-PAY OPTION. I agree to pay prior to my leave under the FMLA, the estimated amount of Medical Flexible Spending Account contributions due for the time period of my FMLA leave. I understand that these payments may be pre-taxed. I further understand that if my FMLA leave is to extend beyond the above-specified date, that I will be responsible for paying these Medical FSA contributions prior to my return to work or immediately upon my return to work. I understand that these payments may be paid on either a pre- tax or post-tax basis. (Pre-tax may be available only if paid prior to the end of the tax or post-tax basis. (Pre-tax may be available only if paid prior to the end of the Plan Year in which the leave commenced).

Medical FSA

2. PAY-AS-YOU-GO OPTION. I agree to make payments to the Medical FSA on the same schedule as payments are made by employees who are not on a FMLA leave. I understand that payments can be pre-tax out of taxable compensation or post-tax. I further understand that if I fail to make the scheduled payments, my Employer is not required to maintain coverage, however, if my Employer voluntarily continues coverage when payments are not made, my Employer may recoup these payments upon my return from the FMLA leave. Should the Employer not elect to continue payments, I understand that the benefit will be terminated and any claims for services received from that point forward would not be eligible for benefits under the Medical FSA. Should coverage be terminated, I acknowledge that I may be reinstated upon return from my FMLA leave, however, any claims incurred during the time coverage was not in effect will not be eligible for benefits under the Medical FSA.

Medical FSA

3. CATCH-UP OPTION. I agree to pay the missed Medical FSA contributions upon my return from the FMLA leave. I understand that my Employer and I must agree in advance to the Spending Account coverage period. I further understand that if I return from the FMLA leave prior to the end of the Plan Year, that the missed contribution(s) can be pre-taxed out of my compensation. If my FMLA leave extends beyond the Plan Year, my contributions must be made on a post-tax basis.

Medical FSA

4. REVOKE ELECTION OPTION. I agree to revoke my election to the Medical FSA. I understand that by revoking my election, that any expenses incurred while on the FMLA leave would not be eligible for benefits under the Medical FSA. I acknowledge that when I return from the FMLA leave, I may be reinstated within thirty (30) days of return to work by completing an Election Status Change Form, however, claims under Medical FSA will be limited to the effective date of the reinstatement (signed Election Status Change Form) through the end of the Plan Year. Any expenses incurred during the FMLA leave would not be eligible for benefits or reimbursement.

DEPENDENT CARE FMLA ELECTION

Dependent Care FSA

1. I AUTHORIZE MY EMPLOYER TO DISCONTINUE MY CONTRIBUTIONS TO THE DEPENDENT CARE FSA DURING MY FMLA LEAVE. I understand that any expenses incurred during my FMLA leave are not eligible for reimbursement unless I am disabled and unable to care for my child(ren). I acknowledge that upon my return from the FMLA leave, I may reinstate my election by completing a new Election Status Change Form within thirty (30) days of returning to work. I further acknowledge that reinstatement will occur on the date the Election Status Change Form is completed and signed.

Dependent Care FSA

2. I ELECT TO CONTINUE MY SALARY REDUCTION TO THE DEPENDENT CARE FSA DURING MY FMLA LEAVE. I understand that this continuation of salary reduction may only remain in effect while I receive taxable compensation from my Employer. I further understand that if no compensation is available for my contribution, I will discontinue contributions until I return from my FMLA leave. I acknowledge expenses during my FMLA leave I incur for Dependent Care are only eligible for reimbursement if I am disabled and unable to care for my child(ren). I further acknowledge that I may make a new election under the Dependent Care FSA within thirty (30) days of my return from the FMLA leave. I understand that the new election will go into effect the date the Election Status Change Form is completed and signed on or after the date of return to work.

I certify the above information to be correct and authorize the new salary reductions as indicated. I understand that the above requested change in my election to the Flexible Benefits Plan is allowed due to my FMLA leave and must remain in effect for the duration of the FMLA leave.

Employee Signature

Date

A copy of this election form must be forwarded to:

Beneflex Inc.

3354 Perimeter Hill Drive

Suite 112

Nashville, TN 37211

Telephone: (800) 925-4087 - (615) 831-0990

Facsimile (800) 449-7501 - (615) 831-9910