# Leave of Absence (LOA) Form
# Health Care Flexible Spending Account (FSA)

| Name (Last, First, MI) | |
|---|---|
| | |
| **Agency/School District Name** | **Employee ID + Last 4 SSN** |
| | - |
| **Dates of Leave** | **Daytime Phone Number** |
| | |

**Leave Designation:**

| | | |
|---|---|---|
| ❑ FMLA Leave | ❑ Short Term Disability | ❑ Workers' Comp |
| ❑ Non-FMLA Leave | ❑ Parental Leave | ❑ Military |

**I request the below option for my Health Care FSA contributions (select one):**

❑ **CATCH UP** - I elect to **catch-up contributions** to my Health Care FSA on my return from LOA. My expected return from LOA is within the plan year. By making this election I confirm that I have read and understand the following –

This election is invalid and I will be unable to catch-up on my contributions if my LOA extends beyond the end of the current plan year.

My period of coverage will extend throughout the LOA and claims for expenses incurred during my LOA will be eligible for reimbursement.

During my LOA my employer has agreed to make contributions to my Health Care FSA. When I return to work the amount of contributions my employer made on my behalf will be recalculated and deducted from my paychecks on a pretax basis. I consider this amount a debt I owe my employer.

I may not change the underlying Health Care FSA election amount on account of commencing or returning from the LOA.

❑ **REVOKE** - I elect to **revoke contributions** to my Health Care FSA during my LOA. By making this election I confirm that I have read and understand the following -

For an LOA of 30 days or less my benefits will be reinstated upon my return. My remaining contributions will automatically be recalculated and deducted from my paychecks for the remainder of the plan year.

For an LOA of more than 30 days my period of coverage will end the first day of my LOA. My ASIFlex Card will be immediately suspended. Claims incurred on and after this date will not be eligible for reimbursement.

Upon expiration of an LOA of more than 30 days I may reinstate benefits by completing and submitting an Election Change Form to the Statewide Benefits Office. This form must be submitted within 31 days of returning to work. Coverage will be effective the first of the month following approval of the submitted form.

I may not change the underlying Health Care FSA election amount on account of commencing or returning from the LOA.

| Employee Signature | Date |
|---|---|
| | |

### What happens to my Health Care FSA if I do not submit a Leave of Absence (LOA) Form?

If Health Care FSA contributions are not received for two consecutive pay periods and no leave form has been filed a hold will be placed on your account.

If you are on unpaid leave for more than 30 consecutive days and do not elect to catch-up contributions your coverage will be revoked effective your last day worked. Claims incurred after this date will not be eligible for reimbursement. Your ASIFlex Card will be immediately suspended.

***NOTE:*** *It is the employee's responsibility to file a Leave of Absence Form with the Statewide Benefits Office PRIOR to going out on leave.*

### Does my Leave of Absence affect my Dependent Care FSA?

Dependent Care expenses are not eligible for reimbursement during a period of leave. You may choose to stop your Dependent Care prior to going on leave by completing an Election Change Form. When you return to work, you will have 31 days to reinstate your coverage.

For more information on Flexible Spending visit the SBO website at *de.gov/statewidebenefits.*

**RETURN THIS FORM TO STATEWIDE BENEFITS OFFICE BY FAX, 302-739-8339.**
**PLEASE CONTACT STATEWIDE BENEFITS OFFICE, AT 1-800-489-8933 WITH QUESTIONS.**