



3125 Airport Parkway, Cambridge, MN 55008
 Metro: 763-552-6053 Toll Free: 888-507-6053 Fax: 763-552-6055
 www.tsainvest.com

A division of Educators Financial Services, Inc.

Section 125 Flexible Benefits Plan – Separation Form

For Plan Year Ending: _____ Employer: _____

Name: _____ SSN: _____

Address: _____

NOTE TO EMPLOYEE: Complete this form for revocation or continuation of Benefits in the Plan Year during which you separate from service. You have a choice between (a) revoking your election (i.e., ceasing salary reductions), or (b) continuing your election and paying the election amount not already deducted from your previous paychecks either out of your final paycheck, or by an after-tax payment to your employer. For each of the categories, please complete *either* A, starting with the checkbox on Line 1, *or* B, starting with the checkbox on Line 4.

A. **Revocation of Elections.** I wish to *revoke* my elections (i.e., cease salary reductions) for the categories completed below (Lines 1, 2 and 3) effective the day I separate from service, and choose to receive only the balance set out on Line 3 for the remainder of the Plan Year. I understand if I return to service, I will not be permitted to make new elections for the rest of the Plan Year except, if I am rehired within 30 days, my previous elections will be reinstated. NOTE: If you revoke your elections, the Plan permits you to be reimbursed Dependent Care, Group-Term Life and Outside Health Insurance expenses (but not Health FSA expenses) incurred after separation from service only up to the amount deducted from your pay.

	Dependent Care	Group-Term Life	Outside Health Ins.	Health FSA
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I revoke (check box):				
1. Year-to-date salary reductions	\$ _____	\$ _____	\$ _____	\$ _____
2. Expenses incurred this Plan Year <u>before</u> separation	_____	_____	_____	_____
3. Amount of expenses incurred <u>after</u> separation date for which I'm entitled to seek reimbursement (1 less 2).	\$ _____	\$ _____	\$ _____	Not reimbursable

B. **Continuation of Elections.** (Do not check any category previously checked in paragraph A above.) I wish to continue my election for each of the categories completed below (Lines 4, 5, 6 and 7).

Dependent Care <input type="checkbox"/>	Group-Term Life <input type="checkbox"/>	Outside Health Ins. <input type="checkbox"/>	Health FSA <input type="checkbox"/>
-----------------------------------------------	------------------------------------------------	----------------------------------------------------	-------------------------------------------

I continue (check box):

4.	Total Election for Plan Year	\$ _____	\$ _____	\$ _____	\$ _____
5.	Less: Salary Reductions to date of separation	(_____)	(_____)	(_____)	(_____)
6.	Any difference (4 less 5)	\$ _____	\$ _____	\$ _____	\$ _____
7.	Amount in Line 6 funded by:				
	a. Final pre-tax pay reduction	_____	_____	_____	_____
	b. After-tax payment	_____	_____	_____	_____*

*After-tax payment will not provide you any tax savings. If Health FSA salary reductions to date of separation are less than Health FSA reimbursements to date of separation you may fund your account pro-rata on a monthly basis. Otherwise you may only continue in the Health FSA if your full election amount is paid upon termination (either by pre-tax pay reduction or after-tax payment).

I acknowledge the revocation and/or continuation of elections made above and authorize the amounts (if any) listed on line 7.a. to be deducted pre-tax from my remaining paycheck(s).

Signature

Date

Health FSA paid through _____, 20____
 Health FSA amount \$_____ due the first
 or each month beginning _____, 20____ to
 continue through end of current plan year.