

Please read this page carefully. Signing the election form means you agree to the following and understand the options you are choosing on the election form and that you understand that your participation is subject to applicable rules in Chapter 60P, Florida Administrative Code.

Follow the instructions below to complete each part of the election form.

- **Part 1 – Participant Information** – To be completed by the terminating employee.
- **Part 2 – Current Status of Your Account** – To be completed by the terminating employee **only if continuing participation**.

To complete each line on the form	Follow these instructions
1. Current MRA Balance	In People First, go to Health & Insurance > Your Benefits > FSA Account Balance in Helpful Links section
2. Annual Elected Amount	In People First, go to Health & Insurance > Your Benefits > FSA Account Information in Helpful Links section
3. Current YTD Contributions	In People First, go to Health & Insurance > Your Benefits > FSA Transactions
4. Remaining Regular Payroll Contributions, if any	Project dollar amount based on your termination date
5. Total Pay YTD Contributions upon Final Regular Payroll	Add lines 3 and 4
6. Balance Due to meet Annual Elected Amount	Subtract line 5 from 2

- **Part 3 – Participant Payment Options** – To be completed by the terminating employee (use dollar amount from line 6 above) and the agency human resource office, if applicable.

Step	Action								
1	Select your Participation Option: <ul style="list-style-type: none"> • To continue, check Box ❶ on the form then go to step 2 below • To terminate, check Box ❷, sign, date and mail your completed form to the People First Service Center 								
2	Select your Payment Option. To check your annual or sick leave accrual balance (in hours) in People First: Click Employee Information > Time and Payroll > Leave Balance Overview								
3	<table border="0"> <tr> <td>If you choose option:</td> <td>Send your form to:</td> </tr> <tr> <td>A or B</td> <td>Your agency HR office for final leave processing</td> </tr> <tr> <td>C</td> <td>The People First Service Center</td> </tr> <tr> <td>D</td> <td>The People First Service Center who will confirm your monthly Contribution amount, including the 2% administrative fee</td> </tr> </table> <p>If you choose an option that requires payment, make your check or money order payable to the Pretax Benefits Trust Fund, write your People First I.D. number on your payment and "MRA balance due" on the memo line, and mail to People First Service Center, PO Box 863477, Orlando, FL 32886-3477</p>	If you choose option:	Send your form to:	A or B	Your agency HR office for final leave processing	C	The People First Service Center	D	The People First Service Center who will confirm your monthly Contribution amount, including the 2% administrative fee
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A or B	Your agency HR office for final leave processing								
C	The People First Service Center								
D	The People First Service Center who will confirm your monthly Contribution amount, including the 2% administrative fee								
4	Mail or fax your completed and signed election form to People First Service Center, PO Box 6830, Tallahassee, FL 32314 or fax to (800) 422-3128								
5	Keep a copy of your completed form for your records								

- For help, call (866) 663-4735 or TTY (866) 221-0268, Monday through Friday, from 8 a.m. to 6 p.m. Eastern time.

Please note. Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.



FLEXIBLE SPENDING ACCOUNT PROGRAM
MRA OPTIONS WHEN EMPLOYMENT ENDS
2011 ELECTION FORM



PART 1: PARTICIPANT INFORMATION - All Fields Required

People First ID:
First Name:
Last Name:
Complete Mailing Address:
Home Phone: Paid: ☐ Biweekly ☐ Monthly
Agency / Department: Termination Date:
Month Day Year

PART 2: CURRENT STATUS OF YOUR ACCOUNT - Complete this section only if you are continuing participation. If not, check box 2 below (see attached instructions).

1) Current Account Balance as of: is \$
Month Day Year
2) Annual Elected Amount: \$
3) Current Year-to-Date Contributions - last deposit on: is \$
Month Day Year
4) Remaining Regular Payroll Contributions (if any): \$
5) Total Plan Year-to-Date Contributions upon Final Regular Payroll - add lines 3 and 4: \$
6) Balance due to meet Annual Elected Amount - subtract line 5 from line 2: \$

PART 3: PARTICIPATION OPTIONS

You must elect to continue participation or terminate participation using this form. If you elect to continue participation, please check box 1 and select your payment option. You must sign and date this form.

☐ 1 I elect to continue participation for the balance of the Plan Year by making my Medical Reimbursement Account premium contributions by the method selected below. I understand that if I do not honor my payment agreement, my participation in the Plan will be terminated and I will not be eligible to file claims for expenses incurred after my period of participation. I understand it is my sole responsibility to make payments by personal check or money order that are required by the due date, payable to the Pretax Benefits Trust Fund. I will not receive any notice of payment due or non-payment. I will not be eligible to resume participation if I am rehired by the State during the current Plan Year.

☐ A. Full payment of balance due (from line 6) \$ made on pretax basis from my annual or sick leave payout. If these funds are not sufficient to pay the Balance Due, I authorize payment of the full amount available, up to the amount listed in this option and I will pay the difference by personal check or money order within 45 calendar days of my leave payout processing date.

☐ B. Partial payment of \$ made on a pretax basis from my annual or sick leave payout. The Remaining Balance of \$ I will pay by personal check or money order within 45 calendar days of the signature date on this form, or the processing date of my leave payout, whichever occurs first. If leave funds are not sufficient to cover the designated partial payment, I authorize payment of the full amount available, up to the partial payment amount listed in this option. I will meet my Remaining Balance Payment by personal check or money order accordingly.

☐ C. Full payment of \$ paid by personal check or money order within 45 calendar days of the signature date on this form.

☐ D. Monthly payments by personal check or money order due on the first day of each month as follows:
Number of Payments of \$ beginning
Payments are due on the first day of each month and should include a 2% administrative fee. Please call People First if you need help.

☐ 2 I elect to terminate Plan Participation. I understand that any claims for expenses incurred after my period of participation will not be eligible for reimbursement and that if I am rehired by the State during the current Plan Year, I will not be eligible to resume participation.

Participant Signature _____ Date _____
Agency HR Signature _____ Date _____

Mail form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314
Fax to (800) 422-3128

Mail payments to People First Service Center • PO Box 863477 • Orlando, FL 32886-3477