Health Care Flexible Spending Account (FSA)
Limited Purpose Flexible Spending Account (LPFSA)
Continuation Election Form

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Participant Information

Name (first, middle initial, last)	Last 4 of SSN

Mailing address (street, city, state, ZIP code)

Coverage Information

Employer: Federal law requires that this notice be issued within 14 days after you become aware of a qualifying event (i.e. termination of employment) that will cause an employee to lose eligibility to participate in the FSA or Limited Purpose FSA program(s). Complete the information above and items 1 through 4 below.

1. Date Health Care FSA or Limited Purpose FSA coverage ends: _____
2. Date of this notice: _____
3. Annual Health Care FSA or Limited Purpose FSA amount elected: _____
4. Balance required to complete plan year: _____

Employer Information

Employer (state agency or UW campus)	Date
Completed by	**Telephone**
	( )

COBRA Continuation Election Agreement *To be completed by participant*

***Participant*:** Please read the information on the back before completing this form. Both this completed form and your payment must be returned to ETF.

I elect to continue my Health Care FSA or Limited Purpose FSA for the remainder of the current calendar year by paying the current balance due (Item 4 above in the *Coverage Information* section) on the following basis: (check one)

☐ One payment of the entire balance due for the year.

☐ In equal monthly installments of $_____for ___ months.
Monthly payments are due and payable to ETF by the 15th of each month. The last payment for this plan year must be received by ETF by December 15 of this year.

I have read and understand the information on the back of this form. I understand that if I fail to make a payment on time, coverage will terminate effective on last day of the month in which the last payment was made. I understand that any unused amounts remaining in my account at the end of the plan year, including the run-out period, will be forfeited. I also understand that I will have no Health Care FSA or Limited Purpose FSA coverage for subsequent plan years.

Signature of Applicant	Date	Telephone
		( )

Employee Trust Fund Use Only

Continued coverage effective		By Date
From (MM/DD/YYYY)	Through (MM/DD/YYYY)	Telephone

Information
Coverage under the Health Care FSA or Limited Purpose FSA program(s) will end for you and/or your spouse and dependent(s) on the date shown in Item 1 in the *Coverage Information* section on Page 1 of this form, unless the Department of Employee Trust Funds receives this completed form postmarked within the 60-day election period as described below.

Under federal law known as COBRA, participants who lose eligibility for Health Care FSA or Limited Purpose FSA reimbursement account coverage may continue the same coverage that was currently in force through the end of the plan year. If you choose to continue, your annual election amount must be paid up by December 15 of this plan year. The carryover provision does not apply to inactive or retired employees whether or not you have contributed your full annual election.

You do not need to continue coverage if you have been reimbursed an amount that is equal to or more than your year-to-date contributions to your Health Care FSA or Limited Purpose FSA. Although there is no tax savings on any out-of-pocket contributions that you make, continuing your coverage will allow you to recover funds that you have contributed to your Health Care FSA or Limited Purpose FSA, but not used at the time of your termination. As long as payments are made, coverage will continue.

If you choose not to continue coverage, medical expenses incurred after the date in Item 1 in the* Coverage Information *section on Page 1 of this form will not be eligible for reimbursement and any funds remaining after all valid claims have been paid will be forfeited.

To elect continuation coverage:

1. Check the payment option of your choice in the *COBRA Continuation Election Agreement* section on Page 1. If you select the monthly payment option, payments are due by the 15th of each month.
2. Sign and date the form.
3. Keep a copy of the form for your records.
4. Attach a check or money order, payable to “Employee Trust Funds,” for the proper amount to cover either the first monthly payment or the entire amount due. It must be postmarked or received by ETF within 60 days of the date of the notice shown in Item 1 or Item 2 on the reverse side, whichever is later.

No monthly billing will be sent and coverage will cease if a scheduled payment is missed.

Note: If you also have a dependent day care FSA, you may not contribute additional funds after your termination date. However, any funds that remain in your account may be reimbursed for valid childcare expenses through the end of the plan year. Valid expenses are those that are incurred for the care of a qualified dependent so that you (and your spouse) can work, look for work or attend school full time.

If you have any questions concerning this procedure, you may contact ETF at 1-877-533-5020.

Return this completed form and your payment, following the above instructions, to:

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P.O. Box 7931
Madison, WI 53707-7931