

Aflac Wingspan Benefit Services
Separation of Plan - Leave of Absence Form

Please use this form to report FSA changes.

NOTE: All fields must be completed.

FSA SEPARATION OF PLAN

Employer Name:
Employer Tax ID:
Employee Name:
Social Security Number:
Type of Coverage: (Check all that apply) <input type="checkbox"/> Unreimbursed Medical <input type="checkbox"/> Dependent Care
Separation Date:
Type of Separation (Check one.): <input type="checkbox"/> Retirement <input type="checkbox"/> Deceased <input type="checkbox"/> Discontinuation of Employment
Date of Last Deduction:
Total Amount of FSA Deductions:
Will employee continue coverage under COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No

LEAVE OF ABSENCE

Employer Name:
Employer Tax ID:
Employee Name:
Social Security Number:
Date of Last Deduction Prior to Leave:
Amount of Last Deduction Prior to Leave:
Did employee elect to continue coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate: <input type="checkbox"/> Pre-pay contribution obligations on a pre-tax basis (provided that the leave doesn't straddle two plan years) <input type="checkbox"/> Make monthly contributions (pre-tax if the employee is on a PAID leave of absence) <input type="checkbox"/> Catch-up contributions upon returning from leave If no, indicate separation date:
Total Amount of FSA Deductions:

RETURN FROM LEAVE OF ABSENCE

Employer Name:
Employer Tax ID:
Employee Name:
Social Security Number:
Date of Return From Leave of Absence:
Date Deductions Will Resume Upon Return From Leave of Absence:
Deduction Amount:

Fax this completed form to (706) 320-2432 **OR** e-mail it to flexsaterms@aflac.com.
Please notify Aflac Wingspan Benefit Services whenever these types of changes occur.

EMPLOYER'S SIGNATURE

DATE

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