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State of Michigan
Civil Service Commission
EMPLOYEE BENEFITS DIVISION
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909
(517) 373-7977 or (800) 505-5011
TDD (517) 241-8046

HEALTH CARE FLEXIBLE SPENDING ACCOUNT CONTINUATION OF COVERAGE FORM

Instructions: Complete this form to continue coverage in the Health Care Flexible Spending Account (FSA) for the current calendar plan year. Sign and date the form, retain a copy for your records, and mail to the above address or fax to (517) 373-3174.

NOTE: This form is intended only for employees who are retiring or departing from State service.

EMPLOYEE INFORMATION

PLEASE PRINT OR TYPE

Name			**Effective Date (Civil Service Use Only)**
Home Address			**Work Phone** Ext.
City	**State**	**Zip Code**	**Home Phone**

Employee ID Number	**Effective Date of Retirement or Departure**	**Last Date Worked**

AUTHORIZED DEDUCTIONS

I authorize the State of Michigan to take out the remainder of my Health Care FSA deductions in my last paycheck. The deduction can only be authorized if the deduction completes the total annual goal. I may continue to submit eligible expenses to WageWorks© through the end of the current plan year's grace period, which is March 15. I may consult my FSA plan booklet for more details regarding Flexible Spending Accounts.

I agree and understand that any misstatement or falsification of material facts will result in my removal from the Spending Account, may cause an IRS and/or state audit with possible additional tax, interest, and penalties; which may result in civil and/or criminal prosecution; and may jeopardize my employment status with the State of Michigan.

I understand that if there are insufficient funds available in my last paycheck for the full amount of my remaining total annual goal that no deduction may be taken and my eligibility will cease at the end of the pay period that my employment ceases unless I pay my remaining total annual goal amount on a post-tax basis.

Employee's Signature	**Date**