

**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 517-284-0078.

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

<b>EMPLOYEE INFORMATION</b>				
<b>Name</b>			<b>Effective Date (Civil Service Use Only)</b>	
<b>Home Address</b>			<b>Work Phone</b>	
			<b>Ext.</b>	
<b>City</b>	<b>State</b>	<b>Zip Code</b>	<b>Home Phone</b>	
<b>Employee ID Number</b>	<b>Effective Date of Retirement or Departure</b>		<b>Last Date Worked</b>	
<b><i>AUTHORIZED DEDUCTIONS</i></b>				
<p>I authorize the State of Michigan to take out the remainder of my Health Care FSA deductions from my remaining pay warrants. The pre-tax deductions can only be authorized if the deductions complete the total annual goal. I may continue to incur eligible expenses through the end of the current plan year's grace period, which is March 15. I may consult the FSA Plan Booklet for more details regarding Flexible Spending Accounts.</p>				
<p>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.</p>				
<p>I understand that if there are insufficient funds available in my final pay warrants 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.</p>				
<b>Employee's Signature</b>			<b>Date</b>	