FLEXIBLE SPENDING ACCOUNT
UNPAID LEAVE OF ABSENCE ELECTION FORM

EMPLOYEE NAME	ID NUMBER	HOME / CELL PHONE	FSA PLAN YEAR

Employees on an unpaid leave of absence (LOA) who participate in a Health Care Flexible Spending Account have the option to either continue or revoke their account during their LOA. Specify which of the following options you wish to elect and return this form to Human Resources-Employee Benefits via email to **HRBenefits@fresnocountyca.gov**, fax to (559) 455-4787, or mail to **2220 Tulare Street, 14th Floor, Fresno, CA 93721**. Please contact Employee Benefits at (559) 600-1810 if you have any questions.

Select one of the options:

☐ **Option 1 – Continue**

By electing this option, I understand I am able to continue my participation in Health Care Spending while I am on an unpaid LOA. I understand that I am responsible for my contribution payments while on an LOA and elect the payment option below:

☐ **Pre-pay.** I elect to pre-pay all or a portion of the contributions for the expected duration of my LOA with pre-tax dollars from taxable compensation received prior to my LOA. **Please note that this election must be submitted to Employee Benefits at least thirty (30) days prior to the start of your LOA, regardless of paid/unpaid status.**

☐ **Pay as you go.** I elect to make after-tax contributions during my unpaid LOA. I understand that by electing this option, the County's third-party administrator, Administrative Solutions, Inc., will collect contributions on a biweekly basis during my LOA. I understand that if I fail to remit these contributions, my coverage will be revoked during my LOA and I will not be eligible to submit claims or utilize my ASIFlex Debit Card for expenses incurred during my LOA.

☐ **Option 2 – Revoke**

I agree to revoke my participation during my unpaid LOA. I understand that I will not be eligible to participate in the Health Care Spending during my LOA and am not eligible to submit claims for reimbursement or utilize my ASIFlex Debit Card for expenses incurred during the period I am on LOA.

Please note the following:

- Failure to return this form will result in your FSA account defaulting to Option 2 – Revoke status.
- If your coverage is revoked – either by choice or by failing to pay your contributions while on LOA – you may choose to lower your annual election or maintain your current annual election by increasing your biweekly contribution. You must complete the Flexible Spending Account: Return from Leave of Absence Election Form and return it to Employee Benefits within thirty (30) days from the date that you return to work.

_____
Employee Signature / Date

Employer's Use Only

Leave Begin Date: Scheduled Return Date: Collect for Pay Period(s): to

Plan Administrator's Signature/Date: _____

GROUP TERM LIFE PORTABILITY APPLICATION - EMPLOYEE (CA)

ReliaStar Life Insurance Company
20 Washington Avenue South, Minneapolis, MN 55401
Phone: 800-955-7736; Fax: 612-342-7626

IMPORTANT NOTE: The Employer and Employee must complete all pertinent information on the following pages.
MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.
Return the completed form to the address shown above.

EMPLOYER / ADMINISTRATOR

Read the certificate to determine eligibility for portability. Complete and sign Page 1 of this Portability Application form. Send this form to the Employee to complete the remaining pages. Include copies of beneficiary designations and assignments.

Employer or Group Name County of Fresno

Group Policy Number 708330 Account Number 001

Hire Date _____ Annual Salary at Termination $_____

Employee Name _____ Employee Birth Date _____

Date Last Worked _____ Coverage Termination Date _____

CURRENT COVERAGE INFORMATION

Employee Basic Life Insurance $_____ Coverage Effective Date _____

Employee Basic AD&D Insurance $_____ Coverage Effective Date _____

Employee Supplemental Life Insurance $_____ Coverage Effective Date _____

Spouse Supplemental Life Insurance $_____ Coverage Effective Date _____

Children's Supplemental Life Insurance $_____ Coverage Effective Date _____

EMPLOYER COMMENTS

_____

_____

_____

EMPLOYER ACKNOWLEDGEMENT

I certify that all above information is true and correct according to the records of the employer.

This form will be: ☐ Handed ☐ Mailed ☐ Emailed to the employee on the following date _____

Authorized Signature _____ Date _____

Print Name _____ Title _____

Email _____ Employer Phone (_____)_____

Employee Name _____

Group Policy Number 708330 Account Number 001

EMPLOYEE INFORMATION

Return the completed form to the address shown on Page 1. The insurer must receive this completed form within 31 days of the Coverage Termination Date. MISSING OR INCOMPLETE INFORMATION WILL DELAY PROCESSING OF THIS APPLICATION.

Employee Name _____ Employee Birth Date _____

Employee Billing Address _____ City _____ State _____ ZIP _____

Employee Phone (_____)_____ Employee SSN _____

PORTABILITY INFORMATION

The maximum amount allowed for portability is shown in the Portability Rider. Read the Portability Rider carefully to determine which coverage(s) are eligible for portability. You may only elect to port coverage that was in effect on the coverage termination date as shown on Page 1 of this Application. You will not be able to elect or increase ported coverage in the future.

Any life insurance amount that is not eligible for portability, or exceeds the maximum, may be converted to an individual policy. If you do not want to apply for portability and only want to receive information about conversion, you may skip the "Portability Elections" and "Evidence of Insurability" sections on this form.

Please contact the employer for copies of the certificate and riders describing coverage.

PORTABILITY ELECTIONS FOR EMPLOYEE COVERAGE

Employee Life Insurance **I Elect to Port *(Select one)*:** ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 10%

Will not exceed the lesser of $750,000 or 5 times Basic Yearly Earnings

Employee AD&D Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.

Employee Life must also be ported.

Will not exceed Employee Life amount ported.

Employee Name _____

Group Policy Number 708330 Account Number 001

PORTABILITY ELECTIONS FOR SPOUSE COVERAGE

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

You must port Employee coverage in order to elect portability of Spouse coverage.

Spouse Name _____ Spouse Birth Date _____

Spouse Life Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Will not exceed total Employee Life amount ported.
Maximum = $750,000

Employee Name _____

Group Policy Number 708330 Account Number 001

PORTABILITY ELECTIONS FOR CHILDREN COVERAGE *(**Applies ONLY to currently Insured Children of the Employee as defined by the Children's Life Insurance Rider.** Include additional pages if space is required for more Children.)*

The use of "child" or "children" in this form means a person insured as a child under the Children's Life Insurance Rider.

You must port Employee coverage in order to elect portability of Children's coverage.

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Child Name _____ Child Birth Date _____

Children's Life Insurance **I Choose to *(Select one)*:** ☐ Elect Coverage ☐ Waive Coverage

If elected, percentage will be the same as Employee Life.
Will not exceed total Employee Life amount ported.
Maximum = $25,000

Employee Name _____

Group Policy Number 708330 Account Number 001

EVIDENCE OF INSURABILITY FOR PREFERRED RATES

Portability is available at the standard rates shown on the attached sheet. If you want to apply for the preferred rates for you or your spouse, then you and your spouse must complete the questions below. If any questions are unanswered, the standard rates will apply.

The use of "spouse" in this form means a person insured as a spouse under the Spouse Life Insurance Rider.

Answer the following questions:

1. Are you terminating active employment due to an inability to perform the regular duties of your occupation? **Employee:** ☐ Yes ☐ No

2. In the last 5 years have you received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

3. In the last 5 years have you been diagnosed, treated, or been given medical advice by a member of the medical profession for: any disorder or disease of the heart or blood vessels (excluding controlled high blood pressure); any kidney disease; any neurological disease or disorder; any liver disease; chronic lung disease (excluding asthma); cancer (excluding non-melanoma skin cancer); stroke; diabetes; rheumatoid arthritis; lupus; Crohn's disease; or ulcerative colitis?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

4. In the last 10 years have you been diagnosed by a member of the medical profession as having a positive HIV test or Acquired Immune Deficiency Syndrome (AIDS) in connections with an application for insurance?
   Employee: ☐ Yes ☐ No
   Spouse: ☐ Yes ☐ No

CONVERSION INFORMATION

If you want to receive life insurance conversion information because: (1) you do not want portability, or (2) your elected ported life amount(s) would be less than 100% of the terminating life coverage amount(s), then please check this box:

☐ Send Conversion Information

ACKNOWLEDGEMENT *(Return the completed form to the address shown on Page 1.)*

- I have read this form and all statements and answers that pertain to me.
- All statements and answers as they pertain to me are true and complete to the best of my knowledge and belief.
- I understand that the statements and answers will be used by the insurer to determine insurability.
- I have received ReliaStar Life Insurance Company's Consumer Privacy Notice and Insurance Information Practices Notice.

Employee Signature _____ Date _____

City and State _____

Spouse Signature[1] _____ Date _____

City and State _____

Owner Signature[2] _____ Date _____

City and State _____

[1] *Spouse Signature is required if Evidence of Insurability is completed above.*

[2] *Owner Signature is required only if the Owner is NOT the Employee.*

Premium Rates for Porting

Group Term Life Insurance

County of Fresno
Group Benefit Plan Number: 708330

Continued ("ported") group term life insurance coverage for insured person(s) will be billed directly by ReliaStar Life Insurance Company. The types of coverage for portability are based on the coverages available under the group policy, and what is approved for portability. Ported coverage is subject to the terms of the group policy.

Please see the chart below and use your current age to determine your cost.

Monthly Rates (per $1,000 of coverage):
Life Insurance—Employee, Spouse

Age	Standard Rate	Preferred Rate
<30	$0.14	$0.08
30-34	$0.18	$0.10
35-39	$0.24	$0.13
40-44	$0.36	$0.23
45-49	$0.56	$0.39
50-54	$0.92	$0.64
55-59	$1.62	$1.00
60-64	$2.90	$1.56
65-69	$5.20	$2.80

Accidental Death & Dismemberment (AD&D) Insurance—Employee
$.035

Children Life Insurance
$0.24

Premiums are billed on a quarterly basis. Each quarterly bill will include a $3.50 billing charge.

Rates shown are guaranteed until December 31 of the current year in which you are eligible to apply for portability.

Group Term Life Insurance is underwritten by ReliaStar Life Insurance Company, a member of the Voya® family of companies. Policy form number LP14GP, Certificate form number LC14GP, Rider form numbers LR14GP-SPR, LR14GP-CHR, LR14GP-ADD and LR14GP-PTS. Form numbers, product availability and provisions may vary by state.

04/15/2015