

**FLEXIBLE BENEFIT PLAN  
QUALIFIED RESERVIST DISTRIBUTION ELECTION FORM**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

---

I hereby elect to receive a qualified reservist distribution from my Health FSA Account balance.

I understand that if my request is approved, I will receive a taxable distribution equal to my contributions to my Health FSA Account for the Plan Year as of the date of this qualified reservist distribution request, minus the reimbursements I have received from my Health FSA Account for the Plan Year as of that date.

I also understand that the following conditions must be met in order for the Employer to make the distribution:

◆ My contributions to my Health FSA Account for the Plan Year as of the date of this qualified reservist distribution request exceed the reimbursements I have received from my Health FSA Account for the Plan Year as of that date.

◆ I am a member of one of the following:

- The Army National Guard of the United States
- The Army Reserve
- The Navy Reserve
- The Marine Corps Reserve
- The Air National Guard of the United States
- The Air Force Reserve
- The Coast Guard Reserve
- The Reserve Corps of the Public Health Services

◆ With this form, I have attached a copy of my order(s) from one of the military organizations described above, indicating that I have been ordered or called to active military duty on \_\_\_\_\_, for a period of at least 180 days or for an indefinite period. The date of my order or call is \_\_\_\_\_.

---

**Employee Certification:** I understand that the distribution will be included in my gross income and will be reported as wages on my Form W-2 for the year in which it is paid to me. I also understand that I will forfeit the right to receive reimbursements for medical care expenses incurred during the period that begins on the date of my distribution request and ends on the last day of the Plan Year and I waive all rights that I may otherwise have, to be reimbursed for expenses incurred during this period. I certify that I have read the information regarding qualified reservist distributions in the Summary Plan Description (SPD), including its description of how to determine the amount of my Health FSA Account that is available for distribution.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

---

**To Be Completed by Employer:**

Employer Name: \_\_\_\_\_ Accepted by: \_\_\_\_\_ Date \_\_\_\_\_