Important Information about Your Participation in
the EMPLOYER NAME Health FSA / Dependent Care FSA

Dear EMPLOYEE NAME,

As a participant in the EMPLOYER NAME Health FSA / Dependent Care FSA, this notice serves to inform you about the timeframe within which you have to submit eligible claims for reimbursement. The following information is important:

- As a result of your employment termination, your participation in the Health FSA / Dependent Care FSA will terminate on _____ (notwithstanding any rights you may have to elect to continue your participation via COBRA).
- You have ____ days following this date in which to submit any qualified medical expenses for reimbursement.
- Only expenses incurred during the period of your participation are eligible for reimbursement.
- After ____ days, any remaining funds will be forfeited.

If you have any questions about which claims are eligible for reimbursement or the process for submitting claims, please refer to the EMPLOYER NAME Health FSA / Dependent Care FSA Summary Plan Description document, or contact Human Resources.