Benefit Plan Administrators
402 Graham Avenue • PO Box 1128 • Eau Claire, WI 54702-1128 PHONE: (800)236-7789 • (715)832-5535 • FAX: (715)838-8507

COBRA FLEXIBLE COMPENSATION PROGRAM CONTINUATION NOTICE

Covered Employee:	SSN Number:

Qualifying Event:

☐ the termination (other than for gross misconduct) of employment of the covered employee;
Date of Termination _____

Coverage under the Flexible Compensation Program has terminated or will terminate due to the above qualifying event. Under federal law, I understand that I have the right to continue participation under the Flexible Compensation Program until the end of the election period or the date the employer ceases to provide any Flexible Compensation Program to any employee.

In order to retain your benefits under the Flexible Compensation Program, you will be required to make the monthly pledge payments of $_____ to the address below:

(Employer's Name and Address)

_____

_____

_____

Your first monthly pledge payment must be received within 45 days of the date of election and subsequent monthly pledge payments must be received by the first day of each participation month.

NOTE: Please keep your Summary Plan Description if you do elect to continue participation in the Flexible Compensation Program.

☐ I **DO** elect to continue participation under the Flexible Compensation Program, and agree to the conditions and requirements outlined above.

☐ I **DO NOT** elect to continue participation under the Flexible Compensation Program.

DATE: _____ **SIGNATURE:** _____