



VitaFlex Medical and Dependent Care Reimbursement Plan Notice of Leave of Absence

Employee Data

Employer Name:		
Employee Name:		
Employee Social Security:		
Plan Year:		<i>Note: If a leave of absence spans two Plan Years, a separate action must be taken and a separate LOA form must be completed for each Plan Year.</i>

Leave of Absence Data

First Date of Leave:	
Expected Return from Leave:	
Date of Last Paycheck Before Leave:	
Expected Date of First Paycheck after Return from Leave:	
Expected Total Missed Salary Reduction Amount During Leave:	

Leave Salary Reduction Election

<input type="checkbox"/> Revoke Election	<input type="checkbox"/> Continued level salary reduction <i>Assumes paycheck continues through entire leave.</i>
<input type="checkbox"/> Lump sum salary reduction prior to leave Amount: \$ _____ Payroll Date: _____	<input type="checkbox"/> Adjusted level salary reduction <i>Assumes paycheck continues through part of leave.</i> Amount: \$ _____ First Adjusted Payroll: _____ Last Adjusted Payroll: _____
<input type="checkbox"/> Lump sum salary reduction after leave Amount: \$ _____ Payroll Date: _____	<input type="checkbox"/> Reinstate coverage at a reduced level <input type="checkbox"/> Reinstate coverage at the prior level
<input type="checkbox"/> After-tax contribution during leave <input type="checkbox"/> Lump Sum Amount: \$ _____ <input type="checkbox"/> Periodic Payment Amount: \$ _____ x _____	Combination of above options Describe: _____ _____ _____
<input type="checkbox"/> Increased level salary reduction after return from leave to Plan Year end. Amount: \$ _____ Initial Payroll Date: _____	

Verification

Employee Signature:	Date:
Employer Signature:	Date:

Employee: Return this Form to your HR Department Prior to Your Leave
Employer: After Processing, Fax this Form to Vita at (650) 961-2285