Preferred Health Plan
of the Carolinas

FLEXIBLE SPENDING ACCOUNT TERMINATION/CHANGE FORM

Employee Name	Employee Social Security Number
Group Name	

Terminate : ❑ Medical Flexible Spending Account ❑ Dependent Child Care Account
❑ HRA

Account Term./Change Date	Month	Day	Year	Final Contribution Date	Month	Day	Year

Grand Total Contributed by Employee	Medical FSA	Dependent Care Acct	HRA
	$	$	$

Other Information:

Signature of Human Resource Personnel:	Today's Date
✍	✍

*It is the employer's responsibility to advise the member of the continuation of account option and COBRA options that may be available to the member.
*Please advise the member that is terminating that he or she have___ days from the date of term in which to file for any expenses that may have been incurred prior to the term date. After the ___ -day grace period expires any remaining dollars are forfeited.

<u>RETURN COMPLETED FORM TO</u>:
Preferred Health Plan of the Carolinas
PO Box 749
Matthews, NC 28106
(704)847-2321 ext 305, (866) 636-0239 ext 305
Fax # (704)847-3014