



## Qualified Reservist Distribution Election Form

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 or 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 *[check the appropriate box]*:

- 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, or
- The Reserve Corps of the Public Health Service.

- 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. *[An order or call to active duty of less than 180 days' duration must be supplemented by subsequent calls or orders to reach a total of 180 or more days.]* The date of my order or call is *[check the appropriate box]*:

- on or after January 1, 2011, or
- before January 1, 2011, but my period of active duty continues on or after January 1, 2011, as reflected in the attached order.

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 above mentioned information regarding qualified reservist distributions and the QRD information in the SEHP FSA Administration Manual.

Please fax completed form and documentation to SEHP at 1-785-368-7180.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
E-Mail Address