Allegiance®
a Cigna Company

Unpaid Leave (12 Week Maximum) Documentation

Please complete this form and forward with the List Bill for all employees that are interrupting or ceasing pre-tax contributions to a medical spending account or a dependent care assistance program due to an unpaid leave.

Employer Name: _____ Date: ___/___/___

Employee's Name: _____ Employee's SS#:

Leave Start Date: ___/___/___ Expected Leave Return Date: ___/___/___

Reason for Leave:

_____

_____

Medical Spending Account ☐ amount per pay period $_____
Dependent Care Assistance Program ☐ amount per pay period $_____

1. I elect to continue the benefits listed above while on unpaid leave ☐

Method of reimbursement:

Early reimbursement through payroll deduction ☐
After tax reimbursement during leave ☐
Retroactive reimbursement through payroll deduction ☐

Employee Signature _____ Date ___/___/___

2. I elect to revoke the benefits listed above while on unpaid leave ☐

I understand that if I return from leave within 12 weeks, I may reinstate my benefit elections by either accelerating pre-tax payments to contribute the full year election amount, or by resuming pre-tax payment of previous per pay period amounts. ***I also understand that if I revoke benefits while on leave, I will not be eligible for reimbursement for claims incurred during the period for which benefits were revoked.***

Employee Signature_____ Date ___/___/___