

**ACTIVE DUTY HEALTH CARE BENEFITS ELECTION FORM**  
(To be filled out ONLY if called to active duty for more than 31 days)

Employee Name \_\_\_\_\_ Employee ID # \_\_\_\_\_

Address \_\_\_\_\_

Agency \_\_\_\_\_ Pay Period Ending \_\_\_\_\_

**Part I – To be completed by Employee:**

I have been called to active duty with the military effective \_\_\_\_\_.

**Medical and Dental Plan Option** (Check one)

- Waive State Medical Plan coverage
- Continue State Medical Plan coverage while on active duty by self-paying monthly contributions
- Waive State Dental Plan coverage
- Continue State Dental Plan coverage while on active duty by self-paying monthly contributions

**Optional Benefits** (Check one or more)

**Vision Hardware Option**

- Waive State Vision Plan coverage
- Continue State Vision Plan coverage while on active duty by self-paying monthly contributions

**Group Life Insurance-** not eligible while on active duty

**Flexible Spending Accounts** (Check one)

- Change Annual Flexible Spending Account election  
New annual amount \$\_\_\_\_\_
- Continue current Flexible Spending Account
  - Medical Flexible Spending Account
  - Dependent Care Flexible Spending Account
- Waive FSA

**Long-Term Disability-** not eligible while on active duty

**Payment Options** (Check one)

- Pre-pay from final paycheck
- Pre-pay from annual leave and/or accrued compensatory leave paychecks (contact agency pay clerk)
- Self-pay; I understand I will be billed each pay period.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_