



**The California State University
FLEXCASH PROGRAM ENROLLMENT AUTHORIZATION**

RESET



Please type or use ball point pen, print clearly. Return completed form to campus Benefits Officer.

SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ENROLLMENT (Check appropriate box) <input type="checkbox"/> ANNUAL/OPEN ENROLLMENT <input type="checkbox"/> NEWLY ELIGIBLE ENROLLMENT <input type="checkbox"/> CHANGE DUE TO PERMITTING EVENT <input type="checkbox"/> CANCELLATION	2. SOCIAL SECURITY NO.	3. MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single
	4. NAME (first) (initial) (last)	

5. PLAN ELECTIONS – Refer to the FlexCash Brochure for cash option election information.		
Cash Option Type	Monthly Payment	Instructions for Completing Cash Option Elections
A. Cash in lieu of medical insurance	\$	If you are electing the cash option in lieu of medical insurance, enter the monthly cash amount in item A, otherwise enter “none.”
B. Cash in lieu of dental insurance	\$	If you are electing the cash option in lieu of dental insurance, enter the monthly cash amount in item B, otherwise enter “none.”
C. Plan Code 381-001	Monthly Total \$	In Item C enter the total monthly cash option amount (sum of the amounts entered in items A and B).

6. Statement of Other Medical and/or Dental Coverage
 This section **must be completed** if you choose cash instead of your own CSU medical and/or dental insurance plans.

I certify that I am covered by another non-CSU medical and/or dental plan(s). I certify that I will maintain coverage in this medical and/or dental insurance plan(s) on an ongoing basis and I agree to notify my campus Benefits Officer within 60 days if I lose coverage under the medical and/or dental insurance plan(s).

Alternative Coverage		Complete this section ONLY if your “other” non-CSU medical and/or dental insurance coverage is through your spouse’s (or domestic partner’s*) plan(s). Spouse’s (or domestic partner’s*) SSN: _____
A. Medical insurance carrier’s name	Policy Number	
B. Dental insurance carrier’s name	Policy Number	

I have reviewed the FlexCash Brochure describing the CSU’s optional FlexCash Plan, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this form are irrevocable during this plan year unless I experience an allowable “family status change event” as defined in these regulations or other permitting events as described in the FlexCash brochure. I understand that my FlexCash enrollment in lieu of medical and/or dental coverage will continue from year to year until I complete a new FlexCash Enrollment Authorization form to change or cancel FlexCash enrollment.

I have read and agree to the terms and conditions of the FlexCash Program as outlined on this form and in the FlexCash Brochure.

Employee’s Signature: ▶	Date Signed: ▶
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FOR CAMPUS USE ONLY

7. Effective Date of Action Mo Day Year -1-			8. Employee CBID		9. Permitting Event Date Mo Day Year			10. Permitting Event Code	
11. Health Form Attached? (HBD12) <input type="checkbox"/> Yes <input type="checkbox"/> No			12. Dental Form Attached? (STD 692) <input type="checkbox"/> Yes <input type="checkbox"/> No		13. Agency Code		14. Unit Code		15. Campus Name

16. Remarks:	17. Authorized Campus Signature I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the CSU FlexCash Program. Signature: ▶
	18. Date Received:

19. Telephone Number:

*Employees who obtain “alternative” non-CSU coverage through a domestic partner are **not** required to submit proof of registration through the Secretary of State process to enroll in the FlexCash Program.

DISTRIBUTION: ORIGINAL - State Controller’s Office

COPY – Campus

COPY- Employee (with privacy notice)