


THE CALIFORNIA STATE UNIVERSITY
Office of the Chancellor
401 Golden Shore
Long Beach, California 90802-4210
(562) 951-4411

Date: September 22, 2003

Code: **TECHNICAL LETTER**
HR/Benefits 2003-25

To: Human Resources Directors
Benefit Officers

From: Cathy Robinson 
Assistant Vice Chancellor
Human Resources Administration

Subject: **New Fill And Print Documents For Employee Benefit Programs**

We are pleased to announce that Human Resources Administration has created new electronic enrollment forms in Adobe Portable Document Format (PDF) to assist campuses in the ongoing administration and enrollment of various employee benefits programs. For ease of processing, the new documents were designed with the following components:

- A “Fill and Print” component that allows the user to complete required fields on the enrollment form via a computer, and subsequently print it for signature.
- A “Drop Down” List of choices, which allows the user to choose the appropriate employee category, permitting event code and organization code, where appropriate.
- A “RESET” button at the top of each form, which allows the user to clear all text from the document.

A list of the available documents (see attached) is provided below:

- Health Care and Dependent Care Reimbursement Account (HCRA/DCRA) Enrollment Form
- HCRA Direct Pay Enrollment Form For COBRA and Leave Without Pay
- FlexCash Enrollment Form
- Miscellaneous Benefits Enrollment Authorization Form

For convenience purposes, these documents will be provided directly to each campus Benefits Representative as an electronic attachment. In order to complete these documents via computer, Adobe Reader must be installed. This program can be downloaded by accessing the following link at: <http://www.adobe.com/products/acrobat/readstep2.html>.

Questions regarding this technical letter may be directed to Michelle Hamilton at (562) 951-4413. This technical letter is also available on the Human Resources Administration’s web site at <http://www.calstate.edu/HRAdm/memos.shtml>.

CR/mh
Attachments

Distribution:

CSU Presidents
Vice Chancellor, Human Resources

Payroll Managers
Director, SOSS

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The California State University
**DEPENDENT CARE/HEALTH CARE REIMBURSEMENT ACCOUNT PLANS
ENROLLMENT AUTHORIZATION**

Please type or print clearly with ballpoint pen. 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"/> 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. **REIMBURSEMENT PLAN ELECTIONS:** To establish a Health Care and/or Dependent Care Reimbursement Account, enter the amount you want to have deducted EACH month from your pay warrant: The minimum monthly deduction amount for each account is \$20.00, up to a maximum of \$416.66, as allowed by the Plan.

Benefit Deduction Item (Pre-Tax)	6. DED/ORG Code	7. Monthly Deduction Amount	SCO Use Only
Health Care Reimbursement Account (HCRA)	378- ____	A. \$ ____ . ____	
Dependent Care Reimbursement Account (DCRA)	380- ____	B. \$ ____ . ____	

8. Coverage Statement

I UNDERSTAND THAT MY ENROLLMENT INTO THE HEALTH CARE AND/OR DEPENDENT CARE REIMBURSEMENT ACCOUNT PLAN(S) IS FOR THE CURRENT PLAN YEAR ONLY. IF I WISH TO CONTINUE ENROLLMENT FOR THE NEXT PLAN YEAR, I MUST RE-ENROLL ANNUALLY DURING OPEN ENROLLMENT.

I hereby agree to have my monthly pay reduced by the amount(s) specified above. I understand that IRS regulations require that my monthly deductions authorized by this form are irrevocable during this plan year, unless I experience an allowable "status change event," as defined in these regulations and described in the Health Care and/or Dependent Care Reimbursement Account brochure(s).

This reduction in pay is effective with the December pay period (unless this is a mid-year enrollment), and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the CSU contribute the amounts to the Reimbursement Account(s) that I have specified on this document. **I also agree to pay the \$2.00 monthly administrative fee through payroll deduction on a post-tax basis. The \$2.00 administrative fee is charged per Plan.**

I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective dates of my participation in the Plan(s) through the end of the Plan Year. Each Plan Year begins on January 1 and ends December 31. All reimbursement requests for the current Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Health Care or Dependent Care Reimbursement Account(s) after that date will be forfeited.

I have read the above statements and agree to the terms and conditions of the Health Care and/or the Dependent Care Reimbursement Account Plan(s) as outlined on this form.

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

9. Effective Date of Action Mo Day Year	10. Employee CBID R01	11. Permitting Event Date Mo Day Year			12. Permitting Event Code 00
		14. Agency Code	15. Unit Code	16. Campus Name	

13. 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 Health Care and/or Dependent Care Reimbursement Plan(s).

Signature:
▶

18. Date Received:	19. Telephone Number:
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The California State University
DEPENDENT CARE/HEALTH CARE REIMBURSEMENT ACCOUNT PLANS
ENROLLMENT AUTHORIZATION
(REV. 08/02) (REVERSE)

TECHNICAL LETTER
HR/Benefits 2003-25
ATTACHMENT A

PRIVACY NOTICE

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the program administrator, for the purposes of identification and account processing.

It is mandatory to furnish all information requested on this form except for marital status, which may be furnished on a voluntary basis. Failure to provide the mandatory information may result in the enrollment action not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the program administrator. Copies of the Health Care /Dependent Care Reimbursement Enrollment Authorization Form(s) are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Personnel/Payroll Services Division, State Controller's Office, P. O. Box 94250, Sacramento, California 94250-5878, Telephone (916) 445-5361.



The California State University
 Health Care Reimbursement Account (HCRA)

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**REQUEST FOR DIRECT PAY ENROLLMENT
 (COBRA AND LEAVE WITHOUT PAY)**

Complete this form and return to the Campus Benefits Representative

Employee Name (First) (MI) (Last)		Social Security Number		Campus	
Address		City		State Zip	
Signature →			Date		
Reason for Request (check one)				Monthly Contribution Amount \$ _____	
<input type="checkbox"/> Separation from Employment Termination Date _____		<input type="checkbox"/> Leave Without Pay Effective Date _____ Expected Length _____ Is this a FMLA leave? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Complete this section if applicant is not the employee					
Name of Applicant		Relationship to Employee		Social Security Number	
Signature →			Date		
Participation Rules:					
<ol style="list-style-type: none"> 1. You must have a balance in your account prior to separation or leave without pay to be eligible for continued participation. No account balance is required if you are on an unpaid Family Medical Leave (FMLA). 2. If request for continued participation is approved, you may participate until the end of the plan year. If you go on leave without pay and it extends beyond the end of the plan year, you will not be eligible to reenroll in the plan until you return to active status. Separated employees are not eligible to reenroll in subsequent years. 3. Participation after separation will be pursuant to COBRA qualification. Under COBRA, federal regulations specify that you and/or your dependent(s) have 60 days (the "Election Period") from the later of the date of notification of a qualifying event, or the loss of coverage to elect to continue participation, and 45 days from the date of election to submit the first contribution to ASI, the Third Party Administrator. Eligibility based on Leave of Absence will be in accordance with the same timelines. 4. You will receive a coupon booklet for payments, which confirms your continued participation. The first payment submitted to ASI must be sufficient to bring the payments current. 5. You will be billed 102% of your monthly contribution (for COBRA and Leaves Without Pay). 6. All payments must be made directly to ASI. If ASI does not receive payments by the 10th of each month, you will lose eligibility to continue participation. 					
Campus Benefits Representative to mail this form to:					
ASI P. O. Box 6044 COLUMBIA, MO 65205-6044 Telephone Number: (800) 659-3035					
CSU Use Only					
Account Balance (at time of Separation or Leave) \$ _____		Actual Monthly Contribution (including 2% fee) \$ _____		Action <input type="checkbox"/> Approved <input type="checkbox"/> Not approved	
Signature of Reviewer →			Title →		Date



The California State University
FLEXCASH PROGRAM ENROLLMENT AUTHORIZATION

C

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			8. Employee CBID R01		9. Permitting Event Date Mo Day Year			10. Permitting Event Code 01	
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)

PRIVACY NOTICE

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the program administrator for the purposes of identification and account processing.

It is mandatory to furnish all information requested on this form except for marital status, which may be furnished on a voluntary basis. Failure to provide the mandatory information may result in the enrollment elections not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Copies of the FlexCash Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Personnel/Payroll Services Division, State Controller's Office, Post Office Box 94250, Sacramento, California 94250-5878.



The California State University
MISCELLANEOUS BENEFITS ENROLLMENT AUTHORIZATION FORM

Instructions:

Completion of this form enrolls or deletes coverage for employees under normal enrollment (at least half time for 6 months and 1 day) and part time Faculty and Coaches (qualified under AB 211 and CB Agreement) eligible for Vision, Life Insurance and Long-Term Disability benefits. Upon separation or loss of eligibility due to reduction of time base below 0.5 (for normal enrollments) or 0.4 (for AB 211 enrollments), deletion of coverage MUST be submitted immediately.

If the employee is ineligible for a particular benefit, place horizontal lines through the DED. CODE (Section 4) and ORG. CODE (Section 5). The effective date of enrollment is the pay period the employee is hired or becomes eligible (Section 7).

Please type or print clearly.

TO: STATE CONTROLLER – PPSD/PAYROLL SERVICES

(1) SOCIAL SECURITY		(2) NAME (FIRST) (MIDDLE) (LAST)			(3) POSITION NUMBER			
					AGENCY	UNIT	CLASS CODE	SERIAL
BENEFIT	(4) DED. CODE	(5) ORG. CODE	(6) CHANGE TYPE		(7) PAY PERIOD		(8) PARTY CODE	
			NEW	DELETE	MONTH	YEAR		
VISION	450	003					3	
LIFE INS.	250	020						
LTD	250	100						
Remarks:								
(9) PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:								
FORM COMPLETED BY (PLEASE PRINT):					AUTHORIZED SIGNATURE:			
CAMPUS NAME			TELEPHONE NUMBER			DATE SIGNED		
ENROLLEE CBID: R01								

Mail Completed Form To:

State Controller's Office
 PPSD/Miscellaneous Deductions Unit
 P.O. Box 942850
 Sacramento, CA 94250

DISTRIBUTION: ORIGINAL - State Controller's Office

COPY - Campus

COPY - Employee