Date: September 22, 2003

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
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)
   □ OPEN ENROLLMENT
   □ NEWLY ELIGIBLE ENROLLMENT
   □ CHANGE DUE TO PERMITTING EVENT
   □ CANCELLATION

2. SOCIAL SECURITY NO.
3. MARITAL STATUS
   □ Married □ 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.

<table>
<thead>
<tr>
<th>Benefit Deduction Item (Pre-Tax)</th>
<th>6. DED/ORG Code</th>
<th>7. Monthly Deduction Amount</th>
<th>SCO Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Reimbursement Account (HCRA)</td>
<td>378-___</td>
<td>A. $_____<strong>.</strong>_</td>
<td></td>
</tr>
<tr>
<td>Dependent Care Reimbursement Account (DCRA)</td>
<td>380-___</td>
<td>B. $_____<strong>.</strong>_</td>
<td></td>
</tr>
</tbody>
</table>

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: _________________________________

FOR CAMPUS USE ONLY

9. Effective Date of Action
   Mo Day Year
   -1.

10. Employee CBID
    R01

11. Permitting Event Date
    Mo Day Year

12. Permitting Event Code
    00

15. Unit Code
16. Campus Name

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: _________________________________
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)

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

Complete this form and return to the Campus Benefits Representative

<table>
<thead>
<tr>
<th>Employee Name (First)</th>
<th>(MI)</th>
<th>(Last)</th>
<th>Social Security Number</th>
<th>Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Zip</td>
</tr>
<tr>
<td>Signature</td>
<td></td>
<td></td>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

Reason for Request (check one)

☐ Separation from Employment
☑ Leave Without Pay
☐ Other

Termination Date

Effective Date

Expected Length

Is this a FMLA leave? ☐ Yes ☐ No

Monthly Contribution Amount

Complete this section if applicant is not the employee

Name of Applicant

Signature

Relationship to Employee

Social Security Number

Date

Participation Rules:

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

Account Balance
(at time of Separation or Leave)

Actual Monthly Contribution
(including 2% fee)

Action
☐ Approved ☐ Not approved

Signature of Reviewer

Title

Date

CSU Use Only
The California State University
FLEXCASH PROGRAM ENROLLMENT AUTHORIZATION

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)
   - ANNUAL/OPEN ENROLLMENT
   - NEWLY ELIGIBLE ENROLLMENT
   - CHANGE DUE TO PERMITTING EVENT
   - CANCELLATION

2. SOCIAL SECURITY NO.

3. MARITAL STATUS
   - Married
   - Single

4. NAME (first) (initial) (last)

5. PLAN ELECTIONS – Refer to the FlexCash Brochure for cash option election information.

<table>
<thead>
<tr>
<th>Cash Option Type</th>
<th>Monthly Payment</th>
<th>Instructions for Completing Cash Option Elections</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Cash in lieu of medical insurance</td>
<td>$</td>
<td>If you are electing the cash option in lieu of medical insurance, enter the monthly cash amount in item A, otherwise enter “none.”</td>
</tr>
<tr>
<td>B. Cash in lieu of dental insurance</td>
<td>$</td>
<td>If you are electing the cash option in lieu of dental insurance, enter the monthly cash amount in item B, otherwise enter “none.”</td>
</tr>
<tr>
<td>C. Plan Code 381-001</td>
<td>Monthly Total $</td>
<td>In Item C enter the total monthly cash option amount (sum of the amounts entered in items A and B).</td>
</tr>
</tbody>
</table>

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

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 123 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: ▶

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? (HED12)
    - Yes
    - No

12. Dental Form Attached? (STD 692)
    - Yes
    - 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)

August 2001
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.

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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

<table>
<thead>
<tr>
<th>(1) SOCIAL SECURITY</th>
<th>(2) NAME (FIRST) (MIDDLE) (LAST)</th>
<th>(3) POSITION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AGENCY UNIT CLASS CODE SERIAL</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>(4) DED. CODE</th>
<th>(5) ORG. CODE</th>
<th>(6) CHANGE TYPE</th>
<th>(7) PAY PERIOD</th>
<th>(8) PARTY CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td>450</td>
<td>003</td>
<td>NEW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LIFE INS.</td>
<td>250</td>
<td>020</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTD</td>
<td>250</td>
<td>100</td>
<td></td>
<td></td>
<td>3</td>
</tr>
</tbody>
</table>

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

MISCBENEFITSNBR (06/03)