Clear Form | Print

CSU 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 ☐ NEW ENROLLMENT
   - ☐ CHANGE DUE TO PERMITTING EVENT (i.e., Change in Status)
   - ☐ CANCELLATION

2. SOCIAL SECURITY NO.

3. MARITAL STATUS ☐ Married ☐ Single

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

5. REIMBURSEMENT PLAN ELECTIONS: To establish a Dependent Care (DCRA) and/or Health Care Reimbursement Account (HCRA), enter the amount you want to have deducted EACH month on a pre-tax basis from your pay warrant. The minimum monthly pre-tax deduction amount for each account is $20.00, up to a maximum of $212.50 for HCRA ($2,550 annual maximum) and $416.66 for DCRA ($5,000 annual maximum), as allowed by the Plan.

For HCRA participants only: If you are interested in obtaining a FSA Debit Card, you must submit a completed "FSA Debit Card Request" form to ASIFlex. If you request the FSA Debit Card, a separate debit-card fee will be deducted directly from your HCRA account by ASIFlex as a one-time, lump sum amount (i.e., $12.00 if your enrollment begins in January, and the amount is prorated if enrollment begins after January). Therefore, your available benefit under the HCRA will be reduced by this debit-card fee. You can adjust your annual HCRA election amount to include the debit-card fee and thereby obtain a higher HCRA benefit; however, your maximum monthly HCRA pre-tax deduction amount cannot exceed $212.50.

Benefit Deduction Item (Pre-Tax)	6. DED/ORG Code	7. Monthly Deduction Amount	SCO Use Only
Dependent Care Reimbursement Account (DCRA) Employee Initial here ___ Please note: This plan is for eligible dependent day care related expenses only	380- 030	A. $ _____. ___	
Health Care Reimbursement Account (HCRA) Employee Initial here ___ Please note: This plan is for eligible health care related expenses only	378- 030	B. $ _____. ___	

8. Coverage Statement

I UNDERSTAND THAT MY ENROLLMENT INTO THE DEPENDENT CARE AND/OR HEALTH CARE REIMBURSEMENT ACCOUNT PLAN(S) IS FOR ONE PLAN YEAR AT A TIME – MY ENROLLMENT WILL NOT AUTOMATICALLY RENEW. 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 on a pre-tax basis by the amount(s) specified above. I understand that IRS regulations require that my monthly pre-tax deductions authorized by this form are irrevocable during this plan year, unless I experience an allowable "change in status event," as defined in these regulations and described in the Dependent Care and/or Health Care Reimbursement Account brochure(s).

This reduction in pay is effective with the December pay period (January pay warrant), 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 from my pay warrant to the Reimbursement Account(s) that I have specified on this form. I also agree to pay the $1.00 monthly administrative fee through payroll deduction on a post-tax basis. The $1.00 monthly administrative fee is charged per Plan.

Each Plan Year begins on January 1 and ends December 31. 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, or the following 2 ½ month grace period extension (January 1 – March 15) if I am enrolled in the Plan(s) through 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 Dependent Care and/or Health 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 Dependent Care and/or Health Care Reimbursement Account(s) Plan(s) as specified on this form and described in the applicable brochure(s).

Employee's Signature: ▶

Date Signed: ▶

FOR CAMPUS USE ONLY

9. Effective Date of Action			10. Employee CBID	11. Permitting Event Date			12. Permitting Event Code
Mo	Day	Year		Mo	Day	Year	
01	-1-	2017	Select				00

13. Remarks:

Open Enrollment

14. Agency Code	15. Unit Code	16. Campus Name
271		CSU-Stanislaus

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 HCRA and/or DCRA Plan(s).

Print Name: Rose Jones

E-mail address: rjones4@csustan.edu

Signature: ▶

18. Date Received:

19. Telephone Number: (209) 664-6730

DISTRIBUTION: ORIGINAL - State Controller's Office COPY – Campus COPY W/PRIVACY NOTICE – Employee

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 employee's gender and marital status, which may be furnished on a voluntary basis. Failure to provide the mandatory information may result in the DCRA and/or HCRA enrollment action(s) not being processed or being processed incorrectly.

The State Controller's Office requires the 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 Claims administrator. Copies of the Dependent Care/Health Care Reimbursement Account Plan(s) 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 Dependent Care and/or Health Care Reimbursement Account Plan(s) Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Personnel/Payroll Operations Bureau, State Controller's Office, P. O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.