

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 (i.e., Change in Status) <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 Dependent Care and/or Health 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
Dependent Care Reimbursement Account (DCRA) Employee Initial here ____ Please note: This plan is for dependent care related expenses <u>only</u>	380- ____	A. \$ ____.	
Health Care Reimbursement Account (DCRA) Employee Initial here ____ Please note: This plan is for medical related expenses <u>only</u>	378- ____	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 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 “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 document. I also agree to pay the \$1.00 monthly administrative fee through payroll deduction on a post-tax basis. The \$1.00 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 or Health Care Reimbursement Account(s) 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		11. Permitting Event Date Mo Day Year		12. Permitting Event Code			
13. Remarks:				14. Agency Code		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). Print Name: _____ Signature: ▶									
18. Date Received:				19. Telephone Number:					

The California State University
DEPENDENT CARE/HEALTH CARE REIMBURSEMENT ACCOUNT PLANS
ENROLLMENT AUTHORIZATION
(REV. 06/11) (REVERSE)

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 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 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 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.