STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

STD. 701R (REV. 10/2014)

Clear Print

FLEXELECT PROGRAM

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Please type or use ballpoint pen and print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office.

SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT *(Check appropriate box)*

A. ☐ Open Enrollment
B. ☐ Newly Eligible Enrollment
C. ☐ Change Due to Permitting Event
D. ☐ Cancellation
E. ☐ COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER

3. NAME *(First, Initial, Last)*

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	**4. For SCO Use Only** DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	**6. For SCO Use Only** Type of Change
Medical Reimbursement Account (MRA)	**352 -**	A. **$**	
Dependent Care Reimbursement Account (DCRA)	**353 -**	B. **$**	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that my FlexElect benefit choices include my existing health and/or dental benefits unless otherwise indicated by new health, dental, or FlexElect Cash Option Enrollment forms submitted during the FlexElect Open Enrollment Period. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during this Plan Year unless I have a "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook.

I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck 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 State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this 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 Medical Reimbursement Account after that date will be forfeited.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE

DATE SIGNED

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION *MO DAY YEAR* -1-

9. EMPLOYEE CBID

10. PERMITTING EVENT DATE *MO DAY YEAR*

11. PERMITTING EVENT CODE

12. HEALTH FORM ATTACHED (HBD - 12) ☐ YES ☐ NO

13. DENTAL FORM ATTACHED (STD. 692) ☐ YES ☐ NO

14. AGENCY CODE

15. UNIT CODE

16. REMARKS

17. AGENCY NAME

18. AUTHORIZED AGENCY 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, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.

20. DATE RECEIVED IN EMPLOYING OFFICE *(mo day year)*

21. TELEPHONE NUMBER (Indicate if CALNET or give area code)

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The Information Practices 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 plan administrator for the purposes of identification and document processing. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in FlexElect 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 FlexElect Reimbursement Account 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 Reimbursement Account Enrollment Authorization forms upon request. Send requests to: State Controller's Office, Personnel/Payroll Operations Bureau, P.O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.