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 $2**25.00** for HCRA ($2,**700** 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 $225.00.

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- 033	A. $ _____. ___	
Health Care Reimbursement Account (HCRA) Employee Initial here ___ Please note: This plan is for eligible health care related expenses only	378- **033**	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	
Select	-1-	2020	Select				Select

13. Remarks:

14. Agency Code	15. Unit Code	16. Campus Name
		Select

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: _____

E-mail address: _____

Signature: ▶

18. Date Received: | 19. Telephone Number:

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

REV. 06/2019 – Plan Year 2020 or later