CSULB RESEARCH FOUNDATION
FLEX CASH ENROLLMENT AUTHORIZATION

Please type or use ball point pen, print clearly—send completed form to the Human Resources Department.

1. Check appropriate Box A. ☐ Annual or Newly Eligible Enrollment B. ☐ Change Due to Permitting Event C. ☐ Cancellation	2. Campus ID Number	3. Marital Status Married ☐ Single ☐
	4. Name (First, initial, Last)	

5. Plan Elections—Refer to the Flex Cash Plan Description for cash option election information.
Check the Flex Cash option(s) you wish to enroll in or cancel:

☐ Cash in lieu of medical insurance ($64 per pay period not to exceed $128 per month)
☐ Cash in lieu of dental insurance ($6 per pay period not to exceed $12 per month)

6. Statement of Other Medical and/or Dental Coverage
This section **must be completed** if you choose cash instead of your own CSULB Research Foundation medical and/or dental insurance plans.

I certify that I am covered by another non-Research Foundation medical and/or dental insurance plan. I certify that I will maintain coverage in the alternative medical and/or dental insurance plan(s) on an ongoing basis and I agree to notify the Research Foundation Human Resources office within 30 days if I lose coverage under the alternative medical and/or dental insurance plan(s).

A Name of Medical Insurance Carrier Policy Number	Name of Medical Insurance Policy Holder
B. Name of Dental Insurance Carrier Policy Number	Name of Dental Insurance Policy Holder

I have reviewed the Flex Cash FAQ describing the CSULB Research Foundation's optional Flex Cash Plan, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Services (IRS) code. 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 of Family Status" as defined in these regulations or other permitting events as described in the Flex Cash FAQ. I understand that my Flex Cash enrollment in lieu of medical and/or dental coverage will continue from year to year until I complete a new Flex Cash Enrollment or Cancellation form. I further understand that the Research Foundation may amend or cancel this program at any time.

I have read and agree to the terms and conditions of the Flex Cash Program as outlined on this enrollment form and in the Flex Cash FAQ.

Employee's Signature _____ Date Signed _____

Entered by _____ Completion Date _____
HR Representative

Effective Date _____ Permitting Event _____

Event Date _____/_____/_____

Health Form Attached ☐ Yes ☐ No Dental Form Attached ☐ Yes ☐ No