CSU The California State University

Clear Form | Print

THE CALIFORNIA STATE UNIVERSITY FLEXCASH PROGRAM ENROLLMENT AUTHORIZATION

Please type or use ball point pen, print clearly. Return completed form to campus Benefits Officer.

SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ENROLLMENT (Check the appropriate box)

☐ NEW ENROLLMENT (Changes effective January 1st)

☐ CHANGE DUE TO PERMITTING EVENT

☐ CANCELLATION

2. SOCIAL SECURITY NO.

3. MARITAL STATUS

☐ MARRIED ☐ SINGLE

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

5. PLAN ELECTIONS – Refer to the FlexCash Brochure for cash option election information.

Cash Option Type	Monthly Payment	Instructions for Completing Cash Option Elections
A. Cash in lieu of medical insurance	$	If you are electing the cash option in lieu of medical insurance, enter the monthly cash amount in item A, otherwise enter "none."
B. Cash in lieu of dental insurance	$	If you are electing the cash option in lieu of dental insurance, enter the monthly cash amount in item B, otherwise enter "none."
C. Plan Code **381-001**	Monthly Total $	In Item C enter the total monthly cash option amount (sum of the amounts entered in items A and B).

6. ATTESTATION OF OTHER QUALIFYING GROUP HEALTH COVERAGE

This section **must be completed** if you choose cash instead of your own CSU medical and/or dental insurance plans.

I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards (see next page). I certify that I will maintain coverage in a qualifying group health plan on an ongoing basis and I agree to notify my campus Benefits Officer within 60 days if I lose coverage under the medical and/or dental insurance plan(s). I understand that an individual health insurance policy (for example, from Covered California or another insurance marketplace) and coverage under Tricare, Medicare and Medi-Cal are not qualifying group health plan coverage for purposes of the FlexCash Benefit Program.

Alternative Coverage	
A. Medical insurance carrier's name	Policy Number
B. Dental insurance carrier's name	Policy Number

Please provide your "other" non-CSU group medical and dental insurance coverage subscriber's plan(s) information below*

Medical Subscriber's SSN: _____

Dental Subscriber's SSN: _____

I understand that my FlexCash election in lieu of Health Coverage will continue from year to year until I take action to change or cancel my enrollment.

I understand that my benefit elections are regulated under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this election are irrevocable until the next scheduled open enrollment unless I have a valid "Change in Status Event" as defined in IRS Code Section 125 or other permitting events.

I have read and agree to the terms and conditions of the FlexCash Program as outlined on this form and in the FlexCash Brochure.

Employee's Signature: ►

Date Signed: ►

FOR CAMPUS USE ONLY

7. Effective Date of Action — Mo | Day -1- | Year

8. Employee CBID — Select

9. Permitting Event Date — Mo | Day | Year

10. Permitting Event Code — Select

11. Remarks: (If you are changing from dental to FlexCash dental or from FlexCash dental to enroll in dental, please upload form CSU 692 separately when uploading to Connect HR for processing by the State Controller's Office.)

12. Agency Code

13. Unit Code

14. Campus Name — Select

15. 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 FlexCash Program.

Signature: ►

16. E-MAIL ADDRESS OF AUTHORIZED CAMPUS BENEFITS OFFICER SIGNER:

17. Date Received:

18. Telephone Number:

*Employees who obtain "alternative" non-CSU coverage through a domestic partner are **not** required to submit proof of registration through the Secretary of State process to enroll in the FlexCash Program.

DISTRIBUTION: **ORIGINAL** – Campus **COPY** – State Controller's Office **COPY**- Employee (with privacy notice)

Revised July 2025

The Affordable Care Act (ACA) establishes a minimum value standard of a benefits of health plan. For a qualifying group health plan to meet the ACA's minimum value standards, the plan must cover at least 60 percent of the total allowed costs of benefits provided under the plan. Employees may refer to their plan's Summary of Benefits and Coverage document to determine if their coverage meets the law's minimum value standards. For more information on qualifying group coverage refer to the FlexCash brochure located on CSU's website at: https://csyou.calstate.edu/Employee-Resources/Benefits/Flexible/Pages/default.aspx.

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 marital status, which may be furnished on a voluntary basis. Failure to provide the mandatory information may result in the enrollment elections 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.

Copies of the FlexCash 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 Enrollment Authorization forms upon request. The official responsible for the maintenance of the forms is: Chief of Personnel/Payroll Services Division, State Controller's Office, Post Office Box 94250, Sacramento, California 94250-5878.