

<i>Flex Cash Enrollment Form</i> California State University, Fresno Athletic Corporation											
1. CHECK APPROPRIATE BOX A. ☐ New Enrollment or Annual Renewal B. ☐ Change Due to Qualifying Event C. ☐ Cancellation											
2. NAME (FIRST, LAST, MI)	3. SOCIAL SECURITY NUMBER	4. MARTIAL STATUS ☐ <i>MARRIED</i> ☐ <i>SINGLE</i>									
5. PLAN ELECTIONS <table><thead><tr><th><u>Cash Option Type</u></th><th><u>Monthly Payment</u></th><th><u>Instructions for Completing Cash Option Elections</u></th></tr></thead><tbody><tr><td colspan="3">A. Cash in lieu of Medical Insurance \$ _____</td></tr><tr><td colspan="3">If you are seeking to elect the medical cash option in lieu of insurance, enter \$118 in Item A</td></tr></tbody></table>			<u>Cash Option Type</u>	<u>Monthly Payment</u>	<u>Instructions for Completing Cash Option Elections</u>	A. Cash in lieu of Medical Insurance \$ _____			If you are seeking to elect the medical cash option in lieu of insurance, enter \$118 in Item A		
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A. Cash in lieu of Medical Insurance \$ _____											
If you are seeking to elect the medical cash option in lieu of insurance, enter \$118 in Item A											
6. STATEMENT OF OTHER MEDICAL COVERAGE This section must be completed if you choose cash instead of medical coverage. <i>I certify that I am covered by another medical insurance plan. I certify that I will maintain coverage in this medical plan on an ongoing basis and I agree to notify the Auxiliary Human Resources/Payroll office within 31 days if I lose coverage under this medical insurance plan.</i> <table><tbody><tr><td><i>A. Medical Insurance carrier's name</i></td><td><i>Policy Number</i></td></tr></tbody></table>			<i>A. Medical Insurance carrier's name</i>	<i>Policy Number</i>							
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I have reviewed the brochure describing the Athletic Corporation's optional FlexCash Plan, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that the 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 enrollment brochure. I understand that my FlexCash enrollment form in lieu of medical coverage will continue from year to year until I complete a new FlexCash Enrollment or Cancellation form. I have read and agree to the terms and conditions of the FlexCash Program as outlined on this enrollment form and in the FlexCash brochure. Employee Signature _____ Date _____											