

Flex Cash Enrollment Form

Agricultural Foundation of California State University, Fresno

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

- MARRIED
- SINGLE

5. PLAN ELECTIONS

<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 electing the medical cash option in lieu of insurance, enter \$148 in Item A, otherwise enter "none."
B. Cash in lieu of Dental Insurance	\$ _____	If you are electing the dental cash option in lieu of insurance, enter \$12 in Item B, otherwise enter "none."
Monthly Total: \$ _____		

6. STATEMENT OF OTHER MEDICAL AND/OR DENTAL COVERAGE

This section must be completed if you choose cash instead of medical and/or dental coverage.

I certify that I am covered by another medical and/or dental insurance plan. I certify that I will maintain coverage in this medical and/or dental plan on an ongoing basis and I agree to notify Human Resources within 31 days if I lose coverage under this medical and/or dental insurance plan.

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

A. Medical Insurance carrier's name

Policy Number

B. Dental insurance carrier's name

Policy Number

Employee Signature _____ Date _____