

## ***Flex Cash Enrollment Form***

Associated Students, Inc. 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."   |
| <b>Monthly Total: \$ _____</b>       |                        |                                                                                                                  |

### **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 \_\_\_\_\_