Flex Cash Enrollment Form

Associated Students

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

Cash Option Type	**Monthly Payment**	**Instructions for Completing Cash Option Elections**
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 of 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 _____