2024 OPEN ENROLLMENT FLEXELECT REIMBURSEMENT ACCOUNTS (STD. 701R)

EXAMPLES & COMMON ERRORS

Example of Correct & Completed Reimbursement Form (STD. 701R)

Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

STD. 701R (Rev. 10/2019)

FLEXELECT PROGRAM

R

Please type or use ballpoint pen and print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office.

SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT (Check appropriate box)

- A. [✓] Open Enrollment
- B. [ ] New Enrollment
- C. [ ] Change Due to Permitting Event
- D. [ ] Cancel Deduction
- E. [ ] COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER: [redacted]

3. NAME (First, Initial, Last): [redacted]

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change
Medical Reimbursement Account (MRA)	352 -	A. $ 225.00	
Dependent Care Reimbursement Account (DCRA)	353 -	B. $ 25.00	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that my FlexElect benefit choices include my existing health and/or dental benefits unless otherwise indicated by new health, dental, or FlexElect Cash Option Enrollment forms submitted during the FlexElect Open Enrollment Period. I understand that 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 in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook.

I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE: [redacted]

DATE SIGNED: 10/3/2024

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION	9. EMPLOYEE CBID	10. TIME BASE/TENURE	11. PERMITTING EVENT DATE (MO / DAY / YEAR)	12. PERMITTING EVENT CODE
01 – 01– 25	R01	FT/Permanent		

13. AGENCY CODE	14. UNIT CODE	15. AGENCY NAME
[redacted]	[redacted]	[redacted]

16. REMARKS

17. AUTHORIZED AGENCY 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, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.
[redacted]

18. EMAIL ADDRESS: [redacted]

19. TELEPHONE NUMBER (Indicate if CALNET or give area code): [redacted]

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year): 10/3/2024

DISTRIBUTION: Original - State Controller's Office Pink - Agency Goldenrod - Employee

Common Errors on STD. 701R

2024 Minimum monthly Medical Reimbursement Account (MRA) amount not in applicable range (Min $10 – Max $266.66)

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STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

STD. 701R (Rev. 10/2019)

FLEXELECT PROGRAM

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SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT (Check appropriate box)

- A. [✓] Open Enrollment
- B. [ ] New Enrollment
- C. [ ] Change Due to Permitting Event
- D. [ ] Cancel Deduction
- E. [ ] COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER [redacted]

3. NAME (First, Initial, Last) [redacted]

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change
Medical Reimbursement Account (MRA)	352 -	A. $ 7.50	
Dependent Care Reimbursement Account (DCRA)	353 -	B. $	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

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I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE [redacted] DATE SIGNED 10/3/2024

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION	9. EMPLOYEE CBID	10. TIME BASE/TENURE	11. PERMITTING EVENT DATE (MO / DAY / YEAR)	12. PERMITTING EVENT CODE
01 – 01– 25	R10	FT/Permanent		

13. AGENCY CODE	14. UNIT CODE	15. AGENCY NAME
[redacted]	[redacted]	[redacted]

16. REMARKS

17. AUTHORIZED AGENCY 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, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.
[redacted]

18. EMAIL ADDRESS [redacted]

19. TELEPHONE NUMBER (Indicate if CALNET or give area code) [redacted]

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year) 10/3/2024

DISTRIBUTION: Original - State Controller's Office Pink - Agency Goldenrod - Employee

Maximum monthly Medical Reimbursement Amount (MRA) amount not in applicable range (Min $10 – Max $266.66)

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STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

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FLEXELECT PROGRAM

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SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT (Check appropriate box)

- A. [✓] Open Enrollment
- B. [ ] New Enrollment
- C. [ ] Change Due to Permitting Event
- D. [ ] Cancel Deduction
- E. [ ] COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER [redacted]

3. NAME (First, Initial, Last) [redacted]

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change
Medical Reimbursement Account (MRA)	352 -	A. $ 575.00	
Dependent Care Reimbursement Account (DCRA)	353 -	B. $	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

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I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE [redacted]

DATE SIGNED 10/3/2024

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION	9. EMPLOYEE CBID	10. TIME BASE/TENURE	11. PERMITTING EVENT DATE MO DAY YEAR	12. PERMITTING EVENT CODE
01 – 01– 25	R01	FT/Permanent		

13. AGENCY CODE	14. UNIT CODE	15. AGENCY NAME
[redacted]	[redacted]	[redacted]

16. REMARKS

17. AUTHORIZED AGENCY 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, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.
[redacted]

18. EMAIL ADDRESS [redacted]

19. TELEPHONE NUMBER (Indicate if CALNET or give area code) [redacted]

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year) 10/3/2024

DISTRIBUTION: Original - State Controller's Office Pink - Agency Goldenrod - Employee

Minimum monthly Dependent Care Reimbursement Account (DCRA) amount not in applicable range (Min $20 – Max $416.66). Employee signature must be between 9/16 – 10/11/2024.

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STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

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SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT (Check appropriate box)

A. [✓] Open Enrollment
B. [ ] New Enrollment
C. [ ] Change Due to Permitting Event
D. [ ] Cancel Deduction
E. [ ] COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER [redacted]

3. NAME (First, Initial, Last) [redacted]

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change
Medical Reimbursement Account (MRA)	352 -	A. $ 100.00	
Dependent Care Reimbursement Account (DCRA)	353 -	B. $ 12	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

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I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited.

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE [redacted]

DATE SIGNED 10/23/2024

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION	9. EMPLOYEE CBID	10. TIME BASE/TENURE	11. PERMITTING EVENT DATE MO / DAY / YEAR	12. PERMITTING EVENT CODE
01 – 01– 25	E-91	FT/Permanent		

13. AGENCY CODE	14. UNIT CODE	15. AGENCY NAME
[redacted]	[redacted]	[redacted]

16. REMARKS

17. AUTHORIZED AGENCY SIGNATURE
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[redacted]

18. EMAIL ADDRESS [redacted]

19. TELEPHONE NUMBER (Indicate if CALNET or give area code) [redacted]

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year) 10/3/2024

DISTRIBUTION: Original - State Controller's Office Pink - Agency Goldenrod - Employee

Maximum monthly Dependent Care Reimbursement Account (DCRA) amount no in applicable range (Min $20 – Max $416.66)

Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

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SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT *(Check appropriate box)*

- A. [✓] Open Enrollment
- B. [ ] New Enrollment
- C. [ ] Change Due to Permitting Event
- D. [ ] Cancel Deduction
- E. [ ] COBRA Continuation of MRA

2. SOCIAL SECURITY NUMBER [redacted]

3. NAME *(First, Initial, Last)* [redacted]

To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B.

BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change
Medical Reimbursement Account (MRA)	352 -	A. $ 0	
Dependent Care Reimbursement Account (DCRA)	353 -	B. $ 675.00	

7. **I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD.**

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I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.

EMPLOYEE SIGNATURE [redacted]

DATE SIGNED 10/3/2024

AGENCY USE ONLY

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01 – 01– 25	S01	FT/Permanent		

13. AGENCY CODE	14. UNIT CODE	15. AGENCY NAME
[redacted]	[redacted]	[redacted]

16. REMARKS

17. AUTHORIZED AGENCY 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, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the State FlexElect Program.
[redacted]

18. EMAIL ADDRESS [redacted]

19. TELEPHONE NUMBER (Indicate if CALNET or give area code) [redacted]

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year) 10/3/2024

DISTRIBUTION: Original - State Controller's Office Pink - Agency Goldenrod - Employee