

# 2024 OPEN ENROLLMENT FLEXELECT REIMBURSEMENT ACCOUNTS (STD. 701R) EXAMPLES & COMMON ERRORS

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

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

Clear Print

#### FLEXELECT PROGRAM

R

STD. 701R (Rev. 10/2019)

		point pen and print clearly Upayroll office. Return co									
SEE PRIVACY NOTICE ON REVERSE											
ENROLLMENT (Check appropriate box		2. SOCIAL SECURI	TYNUMBER								
A. Open Enrollment	Cancel Deduction										
B. New Enrollment	COBRA Continuation	3. NAVE (First, Into	al, Last)								
C. Change Due to Permi	OI MIPO										
To establish a Medical and/or a and deposited in your account(s			the amount you	want to have ded	ucted EACH	l month from your paycheck					
BENEFIT ITEM	4. For \$CO Use Only DED/ORG CODE	5. TOTAL MO TO BE DED	NTHLY AMOUN	Т	6. For SCO Use Only Type of Change						
Medical Reimbursement Acco	unt (MRA)	352 -	A. \$ 225.00	)							
Dependent Care Relmbursement A	Account (DCRA)	353 -	B. \$ 25.00								
7. IUNDERSTAND 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											
EMPLOYEE SIGNATURE						DATE SIGNED					
<b>%</b>				10/3/2024							
AGENCY USE ONLY											
	RO1	10. TIME BASE/TENURE FT/Permanent		VENT DATE AY YEAR	12. PERMIT	TTING EVENT CODE					
13. AGENCY CODE	14. UNF	T CODE	15. AGENCY NAME								
16. REMARKS	_		I hereby certification of the control of the certification of the certif	acting officer of the	erjury as folio herein named	ws: That I am the duly appointed, agency, that I am authorized to amed herein is eligible for enrollment					

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.

18. EMAIL ADDRESS

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)

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

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)

Clear Print

# STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION

STD 7018 (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.									
SEE PRIVACY NOTICE ON REVERSE									
ENROLLMENT (Check appropriate bo	w1		2. SOCIAL SECURITY NUMBER						
A. Open Enrollment	D	Cancel Deduction	2. SOUND SECURITY NUMBER						
B. New Enrollment	E	COBRA Continuation of MRA	3. NAME (First, Initial, Last)						
C. Change Due to Perr	nitting Event								
To establish a Medical and/or a and deposited in your account(			er the amount you want to have deducted EACH month from your paycheck						
BENEFIT ITEM		4. For \$CO Use Only DED/ORG CODE	TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change					
Medical Reimbursement Acc	ount (MRA)	352 -	A. § 7.50						
Dependent Care Relmbursement	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.  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 A									
AGENCY USE ONLY									
8. EFFECTIVE DATE OF ACTION  01 - 01- 25	9. EMPLOYEE CBID R10	10. TIME BASE/TENURE FT/Permanent	11. PERMITTING EVENT DATE 12 MO DAY YEAR	PERMITTING EVENT CODE					
01 01 23									
13. AGENCY CODE	14. UNIT	CODE	15. AGENCY NAME						
16. REMARKS			<ol> <li>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.     </li> </ol>						
			18. EMAIL ADDRESS  20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)						
			19. TELEPHONE NUMBER (Indicate if CALNET or give area code) 10/2/2024						

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

STATE OF CALIFORNIA - DEPARTMENT OF HUMAN RESOURCES REIMBURSEMENT ACCOUNT

**ENROLLMENT AUTHORIZATION** 

STD. 701R (Rev. 10/2019)

#### Clear **Print**

#### FLEXELECT PROGRAM

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 by	ox)			2. SOCIAL SECURITY NUMBER							
A. Open Enrollment	D. [	Cancel Deduction	on								
B. New Enrollment	E.	COBRA Contin	uation	3. NAME (First, Initial, Last)							
C. Change Due to Perr	nitting Event										
To establish a Medical and/or a and deposited in your account			unt enter	r the amount you want to have deducted EAC	H month from your paycheck						
BENEFIT ITEM		4. For \$CO Use DED/ORG Co		TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change						
Medical Reimbursement Acc	ount (MRA)	352 -		A. \$ 575.00							
Dependent Care Relmbursement	t Account (DCRA)	353 -		B. \$							
ONLY AND IF I WISH TO OPEN ENROLLMENT PE I have reviewed the handbe election limitations authoris my existing health and/or of during the FlexElect Open election form are irrevocables as described in the FlexElect I hereby agree to have my paycheck and will continue condition that the State of specified above. I also agr I understand that requests Program through the end of in order to be reimbursed, after that date will be forfeit.	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 A										
(2)		Α/	SENCVI	USE ONLY							
	1										
8. EFFECTIVE DATE OF ACTION  01 - 01- 25	9. EMPLOYEE CBID R01	FT/Perman		11. PERMITTING EVENT DATE 12. PERM MO DAY YEAR	TTING EVENT CODE						
13. AGENCY CODE	14. UN	IT CODE		15. AGENCY NAME							
16. REMARKS  17. AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly application of the herein named agency, that I am authorismake this certification, and that the employee named herein is eligible for in the State FlexElect Program.											
				18. EMAIL ADDRESS	20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)						
				19. TELEPHONE NUMBER (Indicate if CALNET or give	10/3/2024						

# 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.

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION STD. 701R (Rev. 10/2019)

Clear Print

#### FLEXELECT PROGRAM

R

Please type or u should be directed to your pe										oll office	
		SEE	PRIVACY NOTIC	E ON R	EVERSE						
ENROLLMENT (Check appropriate box)				2. SOCI	AL SECURIT	Y N.	MBER				
A. Open Enrollment	D. C	ancel	Deduction								
B. New Enrollment			A Continuation	3. NAME	(Arst, Initia	, Las	ņ				
C. Change Due to Permitting Event	0	f MRA	`								
To establish a Medical and/or a Dependent C and deposited in your account(s) in Item #5A		irsem	ent Account enter	the am	ount you v	vant	to have ded	ucted EA	CH month	from you	r paycheck
BENEFIT ITEM  4. For \$CO Use Only DED/ORG CODE				TOTAL MONTHLY AMOUNT     TO BE DEDUCTED						or SCO ( ype of C	Jse Only hange
Medical Reimbursement Account (MRA)	3	52 -		A. <b>\$</b>	100.00						
Dependent Care Reimbursement Account (DCR	(A) 3.	53 -		B. <b>\$</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.  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 A											
			AGENCY U	ISE ON	LY						
A RESECTIVE DATE OF ACTION 9. EMPLOYEE	CBID	140	IME BASE/TENURE		MITTING EV			12. PERM	ITTING EVEN	T CODE	
01 - 01- 25 E-91		FT/I	Permanent		MO DA		YEAR				
13. AGENCY CODE	14. UNIT COD	DE		15. AGE	NCY NAME						
16. REMARKS				I he qua mai in tr	reby certify iffed and a ke this certi he State Fie AL ADDRES	und ctino ficat exEle	ect Program.	erjury as fr herein nam ne employe	ned agency, e named her	that I am a rein is elig	
				19. TÉL	EPHONE NU	JAMBE	ER (Indicate If CA	LINETOrgiv	e area code)	10	/3/2024

# 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

DISTRIBUTION: Original - State Controller's Office

STD. 701R (Rev. 10/2019)

#### FLEXELECT PROGRAM

R

Please type or use b should be directed to your person								office.		
	SEE	PRIVACY NOTIC	E ON F	REVERSE						
ENROLLMENT (Check appropriate box)			2.800	IAL SECURITY N	UMBER					
A. Open Enrollment D.	Cancel	Deduction								
B. New Enrollment E.		A Continuation	3. NAM	E (First, Initial, La	st)					
C. Change Due to Permitting Event	of MR/	•								
To establish a Medical and/or a Dependent Care is and deposited in your account(s) in Item #5A and		ent Account enter	the am	ount you war	it to have ded	ucted EACH I	month fro	m your paycheck		
BENEFIT ITEM 4. For \$CO Use Only DED/ORG CODE			TOTAL MONTHLY AMOUNT     TO BE DEDUCTED					6. For SCO Use Only Type of Change		
Medical Reimbursement Account (MRA)	352 -		A. <b>\$</b>	0						
Dependent Care Reimbursement Account (DCRA)	353 -		B. \$	675.00						
I UNDERSTAND THAT MY ENROLLMENT I ONLY AND IF I WISH TO HAVE A REIMBUF 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 PlexElect 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 Program through the end of my Plan Year. All in order to be reimbursed. I further understand after that date will be forfeited.	l reimbursem	ent requests for the	nis Plan	Year must b	e postmarked	by June 30 o	f the follo	wing Plan Year		
I HAVE READ AND AGREE TO THE TERMS AND IN THE FLEXELECT HANDBOOK.	AND COND	ITIONS OF THE	FLEXEL	ECT PROGE	RAM AS OUTI	INED ON TH	IIS ENRO	DLLMENT FORM		
EMPLOYEE SIGNATURE						DA	TE SIGNED	)		
34						1	.0/3/2	024		
		AGENCY L	SE ON	LY		•				
8. EFFECTIVE DATE OF ACTION 9. EMPLOYEE CBID	10. 1	TIME BASE/TENURE	11. PE	RMITTING EVEN		12. PERMITTIN	IG EVENT (	CODE		
01 – 01– 25	FT/	Permanent		MO DAY	YEAR					
13. AGENCY CODE 14. I	UNIT CODE		15. AGE	ENCY NAME						
16. REMARKS				TIODITED AGE	NOV CICALITY INC					
II. Harryona			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.							
	3									
			18. EM	AIL ADDRESS				20. DATE RECEIVED IN EMPLOYING OFFICE		
	(mo day year)  19. TELEPHONE NUMBER (indicate if CALNET or give area code)									
			19. 16	LEPHONE NUME	EA (marcate if CA	Live i or give area	code)	10/3/2024		

Pink - Agency

Goldenrod - Employee