HealthComp

SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN
2020 FLEXIBLE BENEFITS PLAN ENROLLMENT/CHANGE FORM

This form is submitted for: ☐ Enrollment ☐ Change ☐ Termination

SECTION A: EMPLOYEE INFORMATION

Employer: Employee's Telephone #:

Employee's Name: Social Security #:

Employee's Address:

Date Eligible to Participate: ____/____/____

City: _____ State: _____ Zip: _____ Date of 1st Payroll Deduction: ____/____/____

Employee's Email Address: _____

SECTION B: PREMIUMS

If you are making contributions for your health coverage, your premiums will be automatically deducted on a pretax basis, unless you sign the Flex Premium Declination below.

FLEX PREMIUM DECLINATION: I do not want to take advantage of the opportunity to pay for my eligible medical/dental/vision and/or life premium(s) with pretax dollars.

Signature_____**Date**_____

SECTION C: SPENDING ACCOUNTS

The maximum allowable annual contributions are:
Dependent Care Reimbursement Account (DCAP) ➔ $5,000
Health Care Reimbursement Account (HCRA) ➔ $2,700

I request the following benefits be payroll deducted Pre-Tax:

Dependent Care Reimbursement Account (DCAP)	$_____ (Annual)	$_____ (Per Pay Period)
Health Care Reimbursement Account (HCRA)	$_____ (Annual)	$_____ (Per Pay Period)

SECTION D: CHANGE IN STATUS

Due to a qualified status change, I am electing to:

☐ **Terminate my participation in the plan**
☐ **Change my Pre-Tax Deduction(s):**
PREMIUM(S) to: $_____
HCRA to: $_____
DCAP to: $_____

Effective Date of Change: _____/_____/_____

SECTION E: TERMINATION OF EMPLOYMENT

Employee's Termination Date: _____/_____/_____ **Final Payroll Deduction:** _____/_____/_____

SECTION F: DECLARATION

I hereby request **participation** in the above plan. I also certify the above information to be correct and true to the best of my knowledge. The reimbursement expenses for DCAP and/or HCRA will be submitted for me and my eligible dependents. I further understand that the deduction(s) will be in effect for the plan year and cannot be revoked unless I experience a change in my family status.

Employee's Signature_____ **Date** _____