# SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN

## 2020 FLEXIBLE BENEFITS PLAN ELECTION FORM

### SECTION A: PARTICIPANT INFORMATION

Employee's Name: _____ Social Security #: _____

Address, City, State, Zip _____ Employee's Telephone # _____

Employee's Email Address _____

### SECTION B: AUTO IMPORT

☐ Yes, I do want to elect Auto Import (**Note: You cannot elect this feature if you elect the Flex Payment Card option**).

☐ No, I do not want to elect Auto Import

I understand that it is my responsibility to notify my Employer immediately of any reimbursement to which I am not entitled. In the event of a mistake as to my eligibility or participation, allocations made to my account, or the amount of distributions, my Employer, at its sole discretion, may make any adjustment it deems necessary. Adjustments may include, but are not limited to, withholding amounts due from the Plan.

### SECTION C: FLEX PAYMENT CARD

☐ I hereby request a flex payment card. If I elect the Flex Payment Card, I understand that I cannot elect the Auto Import feature.

***If you would also like a debit card for your spouse/dependent, please print their name and Social Security Number:***

Spouse/Dependent's Name:_____ Spouse/Dependent's SS#: _____

### SECTION D: DIRECT DEPOSIT AUTHORIZATION FORM

Instructions: Complete the Authorization Agreement for Automatic Deposit. Your signature is required to process this request and you will need to **attach a voided blank check**.

**Authorization Agreement for Automatic Flexible Benefits Reimbursement Deposits**

**I hereby authorize HealthComp Administrators to make deposits into my:**

**____ Checking Account** **____ Savings Account**

**This authority is to remain in full force and effect until HealthComp has received written notification from me of its termination in such time and such manner as to afford HealthComp and my financial institution a reasonable opportunity to act on it.**

_____ _____

**Signature** **Date**