

**SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN  
2021 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 1<sup>st</sup> 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 **2020 maximum allowable** annual contributions are: Dependent Care Reimbursement Account (DCAP) → \$5,000  
 Health Care Reimbursement Account (HCRA) → \$2,750

The **2021 maximum allowable** annual contribution amounts have not been announced yet. You can indicate below if you would like your election amount to be automatically increased to the 2021 maximum allowable annual contribution once it is announced at the end of 2020. The increases are typically about \$50 - \$100 above the current maximum allowable annual contributions.

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

Check the box(es) below if you would like your election(s) to be automatically increased to the 2021 maximum allowable amount.

Dependent Care Reimbursement Account (DCAP) \$ \_\_\_\_\_ (Annual) \$ \_\_\_\_\_ (Per Pay Period)\*   
 Health Care Reimbursement Account (HCRA) \$ \_\_\_\_\_ (Annual) \$ \_\_\_\_\_ (Per Pay Period)\*

\*If you choose to have your election(s) automatically increased to the 2021 maximum allowable amount, your Per Pay Period cost will be recomputed once the final amount is known.

**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: \_\_\_/\_\_\_/\_\_\_

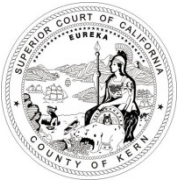
**SECTION E: TERMINATION OF EMPLOYMENT**

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 \_\_\_\_\_



# SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN

## 2021 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