HealthComp

SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN
2024 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 **2023 maximum allowable** annual contributions are: Dependent Care Reimbursement Account (DCAP) ➔ $5,000
Health Care Reimbursement Account (HCRA) ➔ $3,050

The **2024 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 2024 maximum allowable annual contribution once it is announced at the end of 2023. 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 2024 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 2024 maximum allowable amount, your Per Pay Period cost will be recomputed once the final amount in 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

2024 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**