

California State University San Marcos Corporation (CSUSM Corporation)
BENEFITS FOR CASH ENROLLMENT AUTHORIZATION
Please send completed form to the CSUSM Corporation Human Resources Department.

Check Appropriate Box: ☐ New Enrollment ☐ Change ☐ Cancellation

Effective Date: _____

Name (First, Middle, Last) _____

Plan Elections: (Refer to the Benefits for Cash Plan Description)

<u>Cash Option Type</u>	<u>Monthly</u>	<u>Per Pay Period</u>
☐ Cash in lieu of medical insurance	\$ 128.00	\$ 64.00
☐ Cash in lieu of dental insurance	\$ 12.00	\$ 6.00
Monthly Total	\$ _____	\$ _____

Statement of Other Insurance Coverage - This section must be completed if you choose cash instead of your own CSUSM Corporation medical and/or dental insurance plans.

I certify that I am covered by another insurance plan. I certify that I will maintain coverage in this insurance plan on an ongoing basis and I agree to notify the CSUSM Corporation Human Resources Office within 60 days if I lose coverage under this insurance plan.

Medical insurance carrier: _____ Policy Number: _____

Dental insurance carrier: _____ Policy Number: _____

If the insurance coverage is through your spouse/registered domestic partner's plan, please complete:

Spouse/Registered Domestic Partner Name: _____

Spouse/Registered Domestic Partner Signature: _____

I have reviewed the Plan Description of CSUSM Corporation's optional Benefits for Cash Plan, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable unless I lose coverage through uncontrollable circumstances during the plan year. I understand that my Benefits for Cash enrollment in lieu of medical and/or dental coverage will continue for the entire plan year. I also understand that the CSUSM Corporation's Board of Directors reserves the right to amend, change or cancel this plan at any time.

I have read and agree to the terms and conditions of the Benefits for Cash Plan as outlined on this enrollment form and in the Benefits for Cash Plan Description.

Employee Signature _____ Date Signed _____

Benefit Plan Year: 2026