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STATE OF CALIFORNIA – DEPARTMENT HUMAN RESOURCES

CONSOLIDATED BENEFITS (COBEN) CASH ENROLLMENT ELECTION

STD. 702 (REV. 10/2019)

COBEN

Please type or use ballpoint pen, print clearly.
Return completed form to your department's personnel office.

SEE PRIVACY NOTICE ON REVERSE

1. ENROLLMENT *(Check appropriate box)*

A. ☐ Open Enrollment
B. ☐ New Enrollment
C. ☐ Change in Deduction Amount
D. ☐ Cancel Deduction

2. SOCIAL SECURITY NUMBER

3. NAME *(First, Initial, Last)*

PLAN ELECTIONS *Refer to the CoBen Handbook for cash option election information and procedures for completing this form.*

BENEFIT ITEM	ENTER MONTHLY CASH OPTION AMOUNT AND TOTAL	5. FOR SCO USE ONLY Type of Change
4. **CoBen Cash 354-020** **Bargaining Units 2, 7, 8, 16, 17, 18, 19, and Excluded Employees**	A. **Health Only ($130)** $ _____ B. **Health and Dental ($155)** $ _____	

6. ATTESTATION OF OTHER QUALIFYING GROUP HEALTH COVERAGE OR ATTESTATION OF OTHER DENTAL AND QUALIFYING GROUP HEALTH COVERAGE

I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards (see next page) and/or dental insurance plan as indicated below. I certify that I will maintain coverage in a qualifying group health and/or dental insurance plan on an ongoing basis and agree to notify my personnel office within 60 days if I lose coverage.

A. HEALTH INSURANCE PLAN NAME

B. DENTAL INSURANCE PLAN NAME

C. OTHER QUALIFYING GROUP COVERAGE THROUGH (Check one)
☐ Spouse ☐ Domestic Partner ☐ Other _____

D. IF YOUR HEALTH AND DENTAL INSURANCE IS THROUGH YOUR SPOUSE, DOMESTIC PARTNER, OR PARENT, COMPLETE THIS ITEM
Employer: ☐ State ☐ Other
Spouse's, Domestic Partner's, or Parent's Social Security Number

7. **I UNDERSTAND THAT MY COBEN CASH ELECTION IN LIEU OF HEALTH OR HEALTH AND DENTAL COVERAGE WILL CONTINUE FROM YEAR TO YEAR UNTIL I TAKE ACTION TO CHANGE OR CANCEL MY ENROLLMENT OR I ENROLL INTO A STATE-SPONSORED HEALTH AND/OR DENTAL PLAN AT WHICH TIME MY ENROLLMENT WILL BE ADMINISTRATIVELY CANCELLED/CHANGED. IF I ENROLL IN THE CASH OPTION IN LIEU OF DENTAL BENEFITS, I MAY NOT RE-ENROLL IN A STATE-SPONSORED DENTAL PLAN FOR THREE PLAN YEARS AS DESCRIBED IN THE COBEN HANDBOOK.**

IF I AM A PERMANENT INTERMITTENT EMPLOYEE (PIE) I UNDERSTAND THAT THIS CONTINUOUS ENROLLMENT DOES NOT APPLY TO ME AND THAT I MUST RE-ENROLL EACH YEAR DURING THE ANNUAL OPEN ENROLLMENT PERIOD. IF I AM APPOINTED TO A PERMANENT POSITION WITH A TIME BASE OF HALF-TIME OR MORE, I LOSE ELIGIBILITY FOR THE PIE CASH PAYMENT AND MUST NEWLY ENROLL INTO THE CASH OPTION PROGRAM AS A PERMANENT EMPLOYEE.

I understand that my benefit elections are regulated 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 are irrevocable until the next scheduled open enrollment unless I have a valid "Change in Status Event" as defined in IRS Code Section 125 or other permitting events as defined by the Department of Human Resources (CalHR).

I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE COBEN CASH ELECTION AS OUTLINED ON THIS ELECTION FORM AND IN THE COBEN HANDBOOK.

EMPLOYEE SIGNATURE

DATE SIGNED

AGENCY USE ONLY

8. EFFECTIVE DATE OF ACTION *MO DAY YEAR* -1-

9. EMPLOYEE CBID

10. TIME BASE/TENURE

11. PERMITTING EVENT DATE *MO DAY YEAR*

12. PERMITTING EVENT CODE

13. HEALTH FORM ATTACHED (HBD-12) ☐ YES ☐ NO

14. DENTAL FORM ATTACHED (STD. 692) ☐ YES ☐ NO

15. PERMANENT INTERMITTENT ☐ YES ☐ NO

16. AGENCY CODE

17. UNIT CODE

18. REMARKS

19. AGENCY NAME

20. AUTHORIZED AGENCY SIGNATURE
I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency, that I am authorized to make this certification, and that the employee named herein is eligible for enrollment in the Consolidated Benefits.

23. DATE RECEIVED IN EMPLOYING OFFICE *MO DAY YEAR*

21. EMAIL ADDRESS

22. TELEPHONE NUMBER (give area code)

DISTRIBUTION: Original - State Controller's Office; Pink - Agency; Goldenrod - Employee

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*The Affordable Care Act (ACA) establishes a minimum value standard of benefits of a health plan. For a qualifying group health plan to meet the ACA's minimum value standards, the plan must cover at least 60 percent of the total allowed costs of benefits provided under the plan. Employees may refer to their plan's Summary of Benefits and Coverage document to determine if their coverage meets the law's minimum value standards. For more information on qualifying group coverage, refer to the CoBen Handbook on CalHR's website at www.calhr.ca.gov.

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the plan administrator for the purposes of identification and document processing.

It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in enrollment elections not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Copies of the Consolidated Benefits (CoBen) Cash Enrollment Election are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Consolidated Benefits (CoBen) Cash Enrollment Election upon request. Send requests to: State Controller's Office, Personnel/Payroll Services Division, P.O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.