Associated Students | San Diego State University
2010 CAL PERS Employee Benefits Bank Allocation Designation

EMPLOYEE NAME _____
LAST FIRST MIDDLE

SS#:_____ Employee Number:_____ Effective:_____ 26 PAY PERIODS

1. **MONTHLY BENEFITS BANK ALLOCATION**
   Full-Time $786.00
   3/4 Time $590.00
   1/2 Time $393.00
   Enter appropriate dollar amount here: . . . . . $_____

2. **MEDICAL INSURANCE** **Plan Name:**_____ **Plan Code:** _____
   Waive coverage ($0)*
   Employee only ($ _____)
   Employee plus one ($ _____)
   Employee plus two or more ($ _____)
   Enter dollar amount of selected Medical Insurance here: . . . . . $_____

3. **DENTAL INSURANCE**
   Waive Coverage ($0)*
   Employee only ($45.90)
   Employee plus one ($83.43)
   Employee plus two or more ($135.10)
   Enter dollar amount of selected Dental Insurance here: . . . . . $_____

4. **VISION CARE INSURANCE**
   Waive Coverage ($0)
   Employee only ($8.49)
   Employee plus one ($11.41)
   Employee plus two or more ($19.01)
   Enter dollar amount of selected Vision Care Insurance here: . . . . . $_____

5. **TOTAL MONTHLY INSURANCE PREMIUM** . . . . . $_____
   (Total of line 2 through 4)

6. **TOTAL AVAILABLE BENEFITS BANK AMOUNT** $_____ - $_____= $_____
   (line 1) (line 5)

7a. If line 6 is **NEGATIVE AMOUNT** (ie. -$200.00) . . . . . **ENTER AMOUNT HERE** $_____
   This is the monthly amount that will be **DEDUCTED FROM YOUR PAYCHECK** using pretax dollars.

7b. If line 6 is **POSITIVE AMOUNT** (ie. $200.00) . . . . . **ENTER AMOUNT HERE** $_____
   This is the monthly amount of the benefits bank that is available for health care and dependent care reimbursement.

8. If you wish to have additional pretax dollars deducted from your paycheck to pay for qualified health care and dependent care expenses, enter monthly amount here. . . . . $_____

9. Total amount available for health care and dependent care reimbursement accounts. . . . . $_____
   (Total of line 7b and 8)

10. Indicate below the portion of the total from line 9 to be used for Health Care Reimbursement and Dependent Care Reimbursement.

   10A. **HEALTH CARE REIMBURSEMENT** (monthly amount) . . . . . $_____

   10B. **DEPENDENT CARE REIMBURSEMENT** (monthly amount) . . . . . $_____

   ($5,000 Dependent Care Maximum = $416.67 Monthly Maximum)

11. Total amount available for health care and dependent care reimbursement accounts. . . . . $_____
   (The total of lines 10A and 10B MUST equal line 9)

_____ _____
EMPLOYEE SIGNATURE DATE

*Employees electing to waive medical or dental insurance must attach proof of comparable coverage by including a copy of their insurance card or noting employer, carrier and policy number of applicable coverage.

LIST ALL DEPENDENTS TO BE COVERED:

LAST NAME	FIRST NAME	RELATIONSHIP	DATE OF BIRTH	COVERAGE Check Applicable Coverage
				☐ Med ☐ Den ☐ Vis ☐ Flex
				☐ Med ☐ Den ☐ Vis ☐ Flex
				☐ Med ☐ Den ☐ Vis ☐ Flex
				☐ Med ☐ Den ☐ Vis ☐ Flex
				☐ Med ☐ Den ☐ Vis ☐ Flex
				☐ Med ☐ Den ☐ Vis ☐ Flex