

2025 OPEN ENROLLMENT FLEXELECT REIMBURSEMENT ACCOUNTS (STD. 701R) EXAMPLES & COMMON ERRORS

Example of Correct & Completed Reimbursement Form (STD. 701R)

STATE OF CALIFORNIA - DEPARTMENT OF HUMAN RESOURCES

Clear

Print

REIMBURSEMENT ACCOUNT

DISTRIBUTION: Original - State Controller's Office

ENROLLMENT AUTHORIZATION 8TD. 701R (Rev. 10/2019)	FLEXELECT PROGRAM								
Please type or use ballp should be directed to your personnel	oint pen and print clearly /payroll office. Return co	y. Questions regarding completio mpleted form to your department	n of this form 's personnel/payr	oll office.					
	SEE PRIVACY NOTIC	CE ON REVERSE							
ENROLLMENT (Check appropriate box)	_	2. SOCIAL SECURITY NUMBER							
A. ✓ Open Enrollment D.	Canoel Deduction								
B. New Enrollment E.	COBRA Continuation of MRA	3. NAME (First, Initial, Last)							
C. Change Due to Permitting Event									
To establish a Medical and/or a Dependent Care Rein and deposited in your account(s) in Item #5A and/or 8		the amount you want to have dedu	cted EACH month	from your paycheck					
BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	TOTAL MONTHLY AMOUNT TO BE DEDUCTED		6. For SCO Use Only Type of Change					
Medical Reimbursement Account (MRA)	352 -	A. \$ 225.00							
Dependent Care Reimbursement Account (DCRA)	353 -	B. \$ 25.00							
7. I UNDERSTAND THAT MY ENROLLMENT INTO ONLY AND IF I WISH TO HAVE A REIMBURSE OPEN ENROLLMENT PERIOD. I have reviewed the handbook describing the State election limitations authorized under Section 125 my existing health and/or dental benefits unless of during the FlexElect Open Enrollment Period. I un election form are irrevocable during this Plan Year as described in the FlexElect Handbook. I hereby agree to have my monthly pay reduced to paycheck and will continue for each succeeding proondition that the State of California contribute the specified above. I also agree to pay the administral understand that requests for reimbursement mu Program through the end of my Plan Year. All reim order to be reimbursed. I further understand that after that date will be forfeited. I HAVE READ AND AGREE TO THE TERMS ANAND IN THE FLEXELECT HANDBOOK.	te of California's optional Fi of the Internal Revenue Se otherwise indicated by new inderstand that regulations of ar unless I have a "Change by the amount(s) specified only period until the end of the e amounts specified on my rative fee through payroll de st be for eligible services/s imbursement requests for the at any unclaimed amount in	HE NEXT PLAN YEAR I MUST RE- lexElect Program, including the legal ervice (IRS) Code. I understand that health, dental, or FlexElect Cash O under the IRS Code require that my in Status Event" as defined in these above. This reduction in pay is effect the Plan Year. My agreement to he Plan Year. My agreement to behalf to the FlexElect Plan, alloca eduction on a post-tax basis. upplies incurred between the effect his Plan Year must be postmarked to emaining in my Dependent Care an	enroll During al definitions and chamy FlexElect beneint on Enrollment for benefit choices au e regulations or other to be the fit of the enrollment of the enrollment of the enrollment of the enrollment of the various are date of my particle of the formedical Reint of the enrollment of the enrollmen	ange in benefit if choices include if choices inclu					
AGENCY USE ONLY									
8. EFFECTIVE DATE OF ACTION 9. EMPLOYEE OBD	10. TIME BASE/TENURE	11. PERMITTING EVENT DATE MO DAY YEAR	12. PERMITTING EVEN	T CODE					
01/01/2026 R01	FT/Permanent	MO DAY YEAR							
13. AGENCY CODE 14. UNIT	CODE	15. AGENCY NAME							
17. ALTHORIZED AGENCY SIGNATURE I hereby certify under penalty of perjury as follows: That I am the duly a qualified and acting officer of the herein named agency, that I am autho make this certification, and that the employee named herein is eligible f in the State FlexElect Program. 18. EMAIL ADDRESS 20. DATE R EMPLO (mo d) 19. TELEPHONE NUMBER (indicate if CALNET or give area code)									

Goldenrod - Employee

Pink - Agency

Common Errors on STD. 701R

2025 Minimum monthly Medical Reimbursement Account (MRA) amount not in applicable range (Min \$10.00 – Max \$275.00)

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN R	ESON IBOES	CI	lear	Prir	ıt				_	
REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZA STD. 701R (Rev. 10/2019)	IT			FLEXELECT PROGRAM R					R	
Please type or use ballpoint pen and print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office.										
		SEE P	RIVACY NOT	ICE ON I	REVERS	E				
ENROLLMENT (Check appropriate box) 2. SOCIAL SECURITY NUMBER										
A. Open Enrollment	D. Canoel Deduction									
B. New Enrollment	E. 📗		Continuation	3. NAM	E (Arst, Int	dal, Last)				
C. Change Due to Permitting Event		of MRA								
To establish a Medical and/or a Dependent (and deposited in your account(s) in Item #5A			nt Account ente	er the am	ount you	want to have dec	fucted EAC	CH month fro	om your paycheck	
BENEFIT ITEM	ľ		ORG CODE			ONTHLY AMOUN DUCTED	π		SCO Use Only pe of Change	
Medical Reimbursement Account (MRA)	:	352 -		A. \$	A. § 7.50					
Dependent Care Reimbursement Account (DCR	RA)	353 -		B. \$						
OPEN ENROLLMENT PERIOD. I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that my FlexElect benefit choices include my existing health and/or dental benefits unless otherwise indicated by new health, dental, or FlexElect Cash Option Enrollment forms submitted during the FlexElect Open Enrollment Period. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during this Plan Year unless I have a "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook. I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis. I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited. I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK.										
AGENCY USE ONLY										
8. EFFECTIVE DATE OF ACTION 9. EMPLOYEE R10	CBID		Æ BASE/TENURE ermanent	11. PE		EVENT DATE DAY YEAR	12. PERM	ATTING EVENT CODE		
13. AGENCY CODE	14. UNIT C	300E		15. AG	ENCY NAM	Æ				
16. REMARKS										
17. 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 State Flexifiect Program. 18. EMAIL ADDRESS 19. TELEPHONE NUMBER (Indicate if CALNET or give area code) 10/03/2025										
DISTRIBUTION: Original - State Controlle	r's Office	Pin	k - Agency	Golde	nrod - En	nployee				

Maximum monthly Medical Reimbursement Amount (MRA) amount not in applicable range (Min \$10.00 - Max \$275.00)

DISTRIBUTION: Original - State Controller's Office

Clear Print

REIMBURSEMENT AC ENROLLMENT AUTHO		5	FLEXELECT PROGRAM						
			Questions regarding completio mpleted form to your department			office.			
SEE PRIVACY NOTICE ON REVERSE									
ENROLLMENT (Check appropriate box)			2. SOCIAL SECURITY NUMBER						
A. Open Enrollment	D.	Cancel Deduction							
B. New Enrollment	E	COBRA Continuation of MRA	3. NAME (First, Initial, Last)						
C. Change Due to Permittin	g Event								
To establish a Medical and/or a De and deposited in your account(s) in			the amount you want to have dedu	cted EAC	CH month fro	m your paycheck			
BENEFIT ITEM		4. For SCO Use Only DED/ORG CODE	TOTAL MONTHLY AMOUNT TO BE DEDUCTED	6. For SCO Use Only Type of Change					
Medical Reimbursement Accoun	(MRA)	352 -	A. \$ 575.00						
Dependent Care Reimbursement Acc	ount (DCRA)	353 -	B. \$						
OPEN ENROLLMENT PERIOD I have reviewed the handbook election limitations authorized uny existing health and/or denta during the FlexElect Open Enroelection form are irrevocable duas described in the FlexElect H I hereby agree to have my mon paycheck and will continue for condition that the State of Califf specified above. I also agree to I understand that requests for merogram through the end of my in order to be reimbursed. I furt after that date will be forfeited.	describing the State of the State of Section 125 of the State of S	te of California's optional Fi of the Internal Revenue Se therwise indicated by new inderstand that regulations of ar unless I have a "Change by the amount(s) specified by the amount if the end of the e amounts specified on my rative fee through payroll de sist be for eligible services/si indured amount in	HE NEXT PLAN YEAR I MUST RE lexElect Program, including the legi- arvice (IRS) Code. I understand that health, dental, or FlexElect Cash O under the IRS Code require that my in Status Event" as defined in these above. This reduction in pay is effe- the Plan Year. My agreement to have behalf to the FlexElect Plan, allocate aduction on a post-tax basis. upplies incurred between the effect his Plan Year must be postmarked it emaining in my Dependent Care an FLEXELECT PROGRAM AS OUTL	al definition to propose the propose to be perfect of the propose to be perfect on the perfect of the p	ons and char Elect benefit rollment form shoices author ons or other the Decemb y reduced is re e various acc of my particip 80 of the follo ical Reimbur I THIS ENRO	age in benefit choices include is submitted by this permitting events over pay period made on the counts as action in this wing Plan Year sement Account			
36					10/03/2025				
		AGENCY U	ISE ONLY						
	9. EMPLOYEE CBID 10. TIME BASE FT/Perman		11. PERMITTING EVENT DATE MO DAY YEAR	ITTING EVENT CODE					
13. AGENCY CODE				15. AGENCY NAME					
16. REMARKS	•		AUTHORIZED AGENCY SIGNATURE I hereby certify under penalty of pequalified and acting officer of the himake this certification, and that the in the State FlexElect Program.	erein name	ed agency, tha	t I am authorized to			
			18. EMAIL ADDRESS	20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)					
	19. TELEPHONE NUMBER (Indicate if CAL	10/03/2025							

Pink - Agency

Goldenrod - Employee

Minimum monthly Dependent Care Reimbursement Account (DCRA) amount not in applicable range (Min \$20.00 – Max \$625.00). Employee signature must be between 9/15 – 10/10/2025.

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCE REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION STD. 701R (Rev. 10/2019)	Clear	Print FLEXE	ELECT PRO	GRAM	ı		R		
Please type or use ballpoint pen and print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office.									
	SEE PRIVACY NOTIC	E ON REVERS	SE .						
ENROLLMENT (Check appropriate box)		2. SOCIAL SECUR	RITY NUMBER						
A. Open Enrollment D.	Cancel Deduction								
B. New Enrollment E.	of MRA	3. NAME (FIRE, IN	trai, Last)						
C. Change Due to Permitting Event	OI MICC								
To establish a Medical and/or a Dependent Care Rein and deposited in your account(s) in Item #5A and/or 8	mbursement Account enter 3.	the amount you	u want to have dedu	icted EAC	H month fro	m your p	paycheck		
BENEFIT ITEM	4. For SCO Use Only DED/ORG CODE	TOTAL MONTHLY AMOUNT TO BE DEDUCTED 6.				For SCO Use Only Type of Change			
Medical Reimbursement Account (MRA)	352 -	A. \$ 100.0	00						
Dependent Care Reimbursement Account (DCRA)	353 -	B. \$ 12							
ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD. I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that my FlexElect benefit choices include my existing health and/or dental benefits unless otherwise indicated by new health, dental, or FlexElect Cash Option Enrollment forms submitted during the FlexElect Open Enrollment Period. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during this Plan Year unless I have a "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook. I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis. I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited. I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENCOLLMENT FORM AND IN THE FLE									
EMPLOYEE SIGNATURE					DATE SIGNED				
34					10/23/2025				
AGENCY USE ONLY									
A EFFECTIVE DATE OF ACTION 9. EMPLOYEE CBID	10. TIME BASE/TENURE	11. PERMITTING	EVENT DATE DAY YEAR	12. PERM	TTING EVENT C	CODE			
01/01/2026 E-91	FT/Permanent								
13. AGENCY CODE 14. UNIT CODE 15. AGENCY NAME									
16. REMARKS	15. REMARKS 17. ALTHORIZED 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 enrollme in the State FlexElect Program. 18. EMAL ADDRESS 20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)								
DISTRIBUTION: Original - State Controller's Office	Pink - Agency	19. TELEPHONE Goldenrod - Er	NUMBER (Indicate if CAL	NET or give	area code)	10/0	03/2025		

Maximum monthly Dependent Care Reimbursement Account (DCRA) amount not in applicable range (Min \$20.00 - Max \$625.00)

Clear Print STATE OF CALIFORNIA - DEPARTMENT OF HUMAN RESOURCES REIMBURSEMENT ACCOUNT FLEXELECT PROGRAM ENROLLMENT AUTHORIZATION STD, 701R (Rev. 10/2019) Please type or use ballpoint pen and print clearly. Questions regarding completion of this form should be directed to your personnel/payroll office. Return completed form to your department's personnel/payroll office. SEE PRIVACY NOTICE ON REVERSE 2. SOCIAL SECURITY NUMBER 1. ENROLLMENT (Check appropriate box) A. J Open Enrollment Cancel Deduction New Enrollment COBRA Continuation 3. NAME (First, In/dal, Last) of MRA Change Due to Permitting Event To establish a Medical and/or a Dependent Care Reimbursement Account enter the amount you want to have deducted EACH month from your paycheck and deposited in your account(s) in Item #5A and/or B. BENEFIT ITEM 4. For SCO Use Only TOTAL MONTHLY AMOUNT 6. For SCO Use Only DED/ORG CODE TO BE DEDUCTED Type of Change Medical Reimbursement Account (MRA) 352 -0 \$ Dependent Care Relmbursement Account (DCRA) В. 353 s 675.00 7. I UNDERSTAND THAT MY ENROLLMENT INTO THE FLEXELECT REIMBURSEMENT ACCOUNT(S) IS FOR THE CURRENT PLAN YEAR ONLY AND IF I WISH TO HAVE A REIMBURSEMENT ACCOUNT FOR THE NEXT PLAN YEAR I MUST RE-ENROLL DURING THE ANNUAL OPEN ENROLLMENT PERIOD. I have reviewed the handbook describing the State of California's optional FlexElect Program, including the legal definitions and change in benefit election limitations authorized under Section 125 of the Internal Revenue Service (IRS) Code. I understand that my FlexElect benefit choices include my existing health and/or dental benefits unless otherwise indicated by new health, dental, or FlexElect Cash Option Enrollment forms submitted during the FlexElect Open Enrollment Period. I understand that regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during this Plan Year unless I have a "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook. I hereby agree to have my monthly pay reduced by the amount(s) specified above. This reduction in pay is effective with the December pay period paycheck and will continue for each succeeding pay period until the end of the Plan Year. My agreement to have my pay reduced is made on the condition that the State of California contribute the amounts specified on my behalf to the FlexElect Plan, allocated to the various accounts as specified above. I also agree to pay the administrative fee through payroll deduction on a post-tax basis. I understand that requests for reimbursement must be for eligible services/supplies incurred between the effective date of my participation in this Program through the end of my Plan Year. All reimbursement requests for this Plan Year must be postmarked by June 30 of the following Plan Year in order to be reimbursed. I further understand that any unclaimed amount remaining in my Dependent Care and/or Medical Reimbursement Account after that date will be forfeited. I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS OF THE FLEXELECT PROGRAM AS OUTLINED ON THIS ENROLLMENT FORM AND IN THE FLEXELECT HANDBOOK. EMBLOYEE SIGNATURE DATE SIGNED 10/03/2025 Œ AGENCY USE ONLY 8. EFFECTIVE DATE OF ACTION 9. EMPLOYEE CBID 10. TIME BASE/TENURE 11. PERMITTING EVENT DATE 12. PERMITTING EVENT CODE DAY MO 501 FT/Permanent 01/01/2026 13. AGENCY CODE 14. UNIT CODE 15. AGENCY NAME 16. REMARKS 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 State FlexFlect Program. 20. DATE RECEIVED IN 18. EMAIL ADDRESS EMPLOYING OFFICE year) TELEPHONE NUMBER (Indicate if CALNET or give area code)

Original - State Controller's Office

Pink - Agency

Goldenrod - Employee

DISTRIBUTION:

10/03/2025