

**Associated Students of San Francisco State University
Medical Benefit Election Form 6/01/11 thru 5/31/12**

Employee Name	Social Security Number - -
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ELECTION TO PARTICIPATE
I hereby elect to participate in the Associated Students of San Francisco State University Benefit Program. Below I have put an 'X' in my plan selections.

PLAN CHOICES	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
<input type="checkbox"/> KP Chioce 0/1900 HSA				
<input type="checkbox"/> VSP Vision				
<input type="checkbox"/> Health Savings Account	<input type="checkbox"/> Employee Only <input type="checkbox"/> Emp + Dependent(s) H S A can only be elected if high deductible plan is chosen. Associated Students of SFSU will be funding your HSA account: \$158.33 for employee only and \$316.66 for employee + spouse, employee + children and employee+family. Employees will be exempt for Federal taxes on H.S.A employer contributions. Employees will be subject to State taxes on H.S.A employer contributions Please see Patelco H.S.A application to be sure you qualify for an H.S.A account.			

Associated Students of SFSU and I agree that the above-designated amount shall be processed through payroll deductions. By this agreement between Associated Students of SFSU and myself, I understand the following provisions of the Associated Students of SFSU Benefit Program:

- The above election applies to the Plan Year 6/01/11 to 5/31/12 and may not be changed except upon a change in my family status such as: marriage, divorce, death of a spouse or child, birth or adoption of a child, change in spouse's employment such as termination or re-employment, the employee's or spouse's change from part-time to full-time, or full-time to part-time, or a spouse's open enrollment, or the employee or spouse taking an unpaid leave of absence.
- I have been made aware of and understand that all of the appropriate documents relating to the Associated Students of SFSU Benefit Program including the Summary Plan Description, Rate Sheet, Privacy Notice, Initial COBRA Notice and any other relevant Plan Documents or Notices are available to me and my dependents electronically through Nanosyn Intranet or the broker web site at www.filice.com/benefits/asifsfu. I also understand that if I wish to receive a paper copy of any of the above documents, I may do so free of charge by contacting my Human Resource department.

Employee Signature: _____ **Date:** _____

WAIVER OF PARTICIPATION

The plans have been explained to me. If I wish to participate at a later date, I must wait until the next Plan Year, unless there is a change in my family status (e.g. marriage, birth of a child, etc.) at which time I can then enroll in the plan.

Medical Vision

Employee Signature: _____ **Date:** _____