SISC Flex Change Form – 2021 Plan Year
Employer Code: SIS

SISC
Self-Insured Schools of California
Schools Helping Schools

navia benefit solutions

EMPLOYER:	South Orange County Community College District

Employee Information (Please print clearly)

NAME:	First	MI	Last		**SSN:**	
ADDRESS:	Street Address or P.O. Box	City	State	Zip	**PHONE:**	

Indicate employee name, social security number, item(s) to be changed, sign the form and submit to your employer.

Type of change requested:

☐ Change of address
☐ Decrease in monthly deduction amount (indicate new amount below)
☐ Enroll in a plan (indicate election amount below) * Only use change form to enroll if previously completed enrollment form for this year.
☐ Increase in monthly deduction amount (indicate new amount below)
☐ Name change (If you are enrolled in the Health Care or Limited Purpose Expense Account, would you like a new Navia Benefit Card issued? If yes; check box ☐)
☐ Termination from the plan (Must be a qualifying event within IRS guidelines.)
Upon termination, the Navia Benefit Card will be turned off and manual claims may be submitted for the time period the account was active.

This change is due to the qualifying event noted below:

☐ Change in legal marital status, including marriage, divorce, death of spouse, legal separation, or annulment.
☐ Change in number of dependents under Code Section 152, including birth, adoption, placement for adoption, or death.
☐ Change in the employment status of the participant, including (a) termination or commencement of employment, (b) commencement of or return from an unpaid leave of absence, (c) change in employment status that results in the participant, spouse, or dependent child becoming or ceasing to be eligible under the individual's plan (such as switching from part-time to full-time [or from full-time to part-time] employment status.)
☐ Dependent child satisfies or ceases to satisfy dependent eligibility requirements, e.g., attainment of age, student status or any similar circumstances as provided under the Health Benefit plan.
☐ A change in dependent care provider or rates.

DATE OF QUALIFYING EVENT: _____(Change cannot be processed without date of qualifying event.)

Please Note: A qualifying event must have occurred and the requested change must be consistent with that event.
Contact Carmen Gonzales at (661)636-4416 to discuss possible qualifying events.

SISC Flex Plan Elections and Salary Reduction Authorization
SISC Flex Plan is pro-rated if a mid-year election is made.

	Number of Pay Periods remaining		**$ Per Pay Period remaining**
Health Care Expense Account **$2,750.00 yearly maximum**	_____	=	$_____
	Number of Pay Periods remaining		**$ Per Pay Period remaining**
Limited Purpose Health Care Expense Account **$2,750.00 yearly maximum**	_____	=	$_____
	Number of Pay Periods remaining		**$ Per Pay Period remaining**
Dependent Care Expense Account **$5,000.00 yearly family maximum**	_____	=	$_____

I hereby authorize and direct my employer to reduce my salary pre-tax by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

Employee Signature_____ **Date:** _____

Return the completed form to your employer.

Employer's Use Only:
Effective date of change: _____ First Payroll Deduction**:** _____

Received and approved by authorized employer administrator:_____ **Date:** _____

(This change form must be received, processed, and approved by the SISC Flex office before the change becomes effective.)

Return completed form to SISC Flex via:

Secure E-mail System: https://securemail.kern.org or https://filetransfer.kern.org
Mail: P.O. Box 1808
E-mail Address: cagonzales@kern.org Fax: (661)636-4063 Bakersfield, CA 93303-1808