# ATTENDANCE CLERK MANUAL

OFFICE OF HUMAN RESOURCES

REVISED 06/2016

**Department of General Services - Office of Human Resources**

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# Attendance Clerk Manual Foreword

The purpose of the Attendance Clerk (AC) Manual is designed to provide instructions to the AC of Department of General Services (DGS) and its client agencies with the necessary information and resources to perform the various Human Resources (HR) functions. This manual was prepared to provide the information needed to inform and make defensible decisions and produce quality work products in accordance with personnel-related laws, rules, policies, processes, and procedures.

# Attendance Clerk Role and Duties

The Attendance Clerk role is to act as liaison between his/her office employees and the Office of Human Resources (OHR) on issues related to appointments, separations, benefits, payroll and timekeeping (PAL and/or STD 634). Duties associated with this role require the Attendance Clerk to work with confidential employee information and meet stringent deadlines.

Duties may include:

- Distribute and maintain all communication from OHR to office employees.
- Inform OHR of all new hires, transfer and separations through the ABMS database.
- Coordinate and forward complete appointment and separation packages to OHR timely.
- Ensure health, dental, disability benefit and all other related forms associated to personnel are complete and submitted to OHR timely.
- Enter and/or correct employee's time in PAL or on STD 634
- Ensure PAL timesheets/or STD 634 are submitted and approved timely.
- Ensure MSA's, annual performance appraisals, range change and pending probationary report are completed by supervisor, signed by employees and submitted to OHR timely.
- Generate ABMS and PAL reports as appropriate.
- May work closely with an Administrative Assistant who handles the more complex human resources issues such as; initiating the hiring process, tracking/justifying position for the office and special pay request.

# Confidential Data

The Attendance Clerk shall take all necessary precautions to protect the confidentiality of records containing personal information and to assure such records are not disclosed to unauthorized individuals or entities as stated in the provisions of the information Practices Act, Civil Code Sections 1798 through 1798.78. This information includes documents received by the employee for benefits and payroll as well as information maintained in the Activity Based Management System (ABMS) and Project, Accounting and Leave (PAL) system.

For detailed information regarding the information Practices Act, go to the official California Legislative Information website at www.leginfo.ca.gov/calaw.html.

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# Appointment Types

This Manual Section

- Identifies the various types of appointments
- Provides a brief description of each type of appointment
- Explains the TAU appointment process including the Attendance Clerk's responsibilities in the recruitment process

***Note*:** Persons new to State service are appointed from open examination lists; Current State employees' movement may be possible through another appointment procedure such as promotions, transfers, demotions and/or reinstatements.

This chapter contains the following topics:


| Topic | See Pages |
|---|---|
| Promotions | 2 |
| Transfer | 2 |
| Voluntary Transfer | 3 |
| Involuntary Transfer | 3 |
| Demotions | 4 |
| Training and Development (T&D) | 4 |
| Out of Class Assignments (OOC) | 4 |
| Career Executive Assignments (C.E.A) | 4 |
| Exempt | 5 |
| Temporary Authorization Appointments (TAU) | 5 |
| Limited Exam Appointment (LEAP) | 5 |
| Emergency | 5 |

# Types of Appointments *Continue*

**Promotion**

"Promotion" means the appointment of an employee to a position in a different classification with a higher salary range, unless the appointment is by transfer (see Government Code Section 18525.3). Promotions occur when:

- Movement to specialist and supervisory/management classifications
- Does not have to be movement within a series
- Increase in salary 10% or greater
- Appointment from a list

"Promotion-in-place" applies when:

- No true vacancy exists
- There is no change of position, assignment, or supervisory/subordinate relationship
- The promotion is clearly identified as typical in cases where the employee is to move to the next higher level in a class series
- Applies when a working-level position is under-filled at a lower level for recruitment, training and development, and when the employee's job performance and skill development support upgrade of the position to a higher level
- Does not apply to movement to, from or between specialist or supervisory/management classifications
- Entry to journey level list appointment

**Transfers**

A transfer is the appointment of an employee to another position in the same class or to a position in a different class that has substantially the same level of duties, responsibility, and salary and can be under the same or another appointing authority. Transfers are discretionary on the part of management and can be either voluntary or involuntary on the part of the employee.

# Type of Appointments *Continue*

**Voluntary Transfers**

Voluntary transfers are permissive situations that allow an employee to elect to move to a new job or classification within the same or a different department.

- *Employees do not need to meet the minimum qualifications of the "to" classification in order to transfer.
- The employee may be required to serve a new probationary period.
- All transfers must be based on a permanent appointment, either probationary or permanent status (typically the employee's highest permanent list appointment.)
- A limited-term or temporary appointment cannot be used for transfer purposes.
- An employee who has only been appointed on a permanent-intermittent basis can only transfer to a classification on an intermittent basis unless s/he meets the criteria to increase their time based or receives a list appointment to another time base.
- Consecutive transfers shall not be permitted when their combined result would provide the employee with a promotion (salary of two steps or more) as this is contrary to the Constitution of the State of California.

**NOTE:* DGS has the discretion to set departmental policy to impose a transfer restriction as long as the restriction ties back to the minimum qualifications of the "to" classification. Therefore, DGS can require an employee to meet certain restrictions prior to transferring to the classification, such as meet the minimum educational requirements; pass a written test, etc.

**Involuntary Transfers**

Involuntary transfers occur when the movement of an employee is **without** his/her consent to a different classification and/or work location.

These transfers are typically the result of budget or staff reductions and may require a department to move an employee into a new job, classification, and/or location because of layoff, position reassignment, reorganization, etc. Involuntary transfers must be made to a classification with substantially the same level of duties, responsibilities, and salary as the classification the employee is being involuntarily transferred from. The involuntary transfer cannot result in a promotion.

# Type of Appointments *Continue*

**Demotions**

A voluntary demotion is a movement to a class with a lower salary range upon the request or concurrence of an employee. This is distinguished from an involuntary demotion, which is not at the concurrence of the employee and which may occur due to a rejection on probation, in lieu of layoff, or disciplinary action.

A voluntary demotion may be:

- Within the department
- Between departments with the concurrence of the appointing department
- Initiated by the employee
- Initiated by management can only occur when both the employee and management mutually agree.

Employees may request a voluntary demotion. The employee must submit his/her request in writing. The written request must be in the employee's own words with his/her signature stating the reason he/she is requesting the demotion.

If the voluntary demotion moves the employee from a confidential, supervisory or managerial position to a represented classification, the employee must also include a statement acknowledging his/her understanding of the change or loss of benefits.

**Training and Development (T&D)**

T & D Assignments are used to broaden an employee's skills and abilities in their present occupation, prepare them for careers in different occupational fields or improve their advancement potential. Assignments are not to exceed two years and may be in the same or a different department.

**Career Executive Assignments (C.E.A.)**

Career Executive Assignment (C.E.A.) is an appointment to a high level administrative and policy-influencing position within the State civil service in which the incumbent's primary responsibility is the managing of a major function or rendering of management advice to top-level administrative authority. Such a position can be established only in the top managerial levels of State service and is typically responsible for policy implementation and extensive participation in policy development.

# Type of Appointments *Continue*

## Exempt

Employee is appointed or elected to State government positions without competing in an examination. The same rules and regulations as civil service employees do not bind exempt appointees

### Temporary Authorization Appointments (TAU)

Temporary Authorization (TAU) is an appointment made when an appropriate employment list is not available. No person may serve in one or more positions under temporary appointment longer than nine (9) months in twelve (12) consecutive months.

It is the policy of the DGS that the use of temporary authorization utilization (TAU) appointments shall be considered only after all other options have been exhausted. TAU's must be approved in advance of appointment.

***Important!*** **TAU recruitments must be reviewed and conditionally approved by the Selections Unit Manager prior to the interview process.**

### Limited Exam Appointment Program (LEAP)

LEAP is an alternative selection program for persons with disabilities. The State Personnel Board (Board) established the program on January 1, 1989 pursuant to *Government Code, Section 19240* et seq. It is designed to minimize the adverse impact of the traditional selection process by providing an alternate means of assessing the qualifications and skills of job applicants with disabilities. LEAP facilitates the recruitment of applicants with disabilities to provide departments with qualified referrals for selected job classifications.

## Emergency

Emergency appointments provide flexibility for responding to staffing needs that are urgent, unusual and/or short term that cannot be met through the civil service appointment process. Emergency appointments may respond to true emergencies such as fire or flood, or fill temporary vacancies in established positions. They are limited to 60 working days in a 12-month period.

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# Appointment Tenure & Time Base Information

This Manual Section

- Tenure identifies the length of the contract or appointment between the employee and the hiring agency under which the employee is serving

- Time base defines the amount of time an employee is required to work during a specific time period

This section contains the following topics:


| Topic | See Page |
|---|---|
| Tenure Types | 8 |
| Permanent Appointment | 8 |
| Permanent Intermittent (PI) | 8 |
| Limited Term | 9 |
| Temporary Authorization Appointment (TAU) | 9 |
| Retired Annuitant | 9 |
| Career Executive Assignments (C.E.A.) | 10 |
| Emergency Appointment | 10 |
| Time Base | 11 |

# Tenure

This section describes “tenures” and employee status in civil service and refers to the rights and privileges that employees gain from successful competition in an examination.

The term ‘status’ is usually applied only to permanent or probationary employees or, in some cases to other types of employees who have previously had permanent or probationary status. Employees gain status rights in classifications rather than positions, since a civil service examination covers all of the positions within a class.

Employees serving under limited term or temporary authorization appointments do not acquire status in a position or class from such appointments. However, such service maintains the continuity of State service and, thereby, preserves previously acquired status rights.

**Tenure Types**

Tenure identifies the length of the contract between the employee and the hiring agency. The following are tenures used in State service:

- Permanent Appointment
- Permanent Intermittent (PI)
- Limited Term
- Temporary Authorization Appointment (TAU)
- Retired Annuitant
- Career Executive Assignments (C.E.A.)
- Emergency Appointment

**Permanent Appointment**

A permanent appointment is defined as an employee who has been certified and appointed from an employment list to a permanent position, or has been reinstated after resignation, or has been transferred or demoted but who has not completed the probationary period. Probationary periods are only served for permanent appointments.

Permanent status is attained by an employee through completing the probationary period for the position serving.

**Permanent Intermittent (PI)**

Intermittent employees are contacted on an “as needed” basis. They are not guaranteed any specific hours. PI may work up to a maximum of 1500 hours in a calendar year (Jan 1 – Dec 31) and shall **not** be used to fill full time or part time positions.

# Tenure *Continue*

### Limited Term (LT)

Limited Term appointments are made from civil service employment lists, by reinstatement or transfer, for periods of up to two years to meet various limited term staffing needs. Limited term appointments are distinguished from permanent and probationary appointments by the fact that they are made for a limited duration and do not confer civil service employment rights beyond the specified time period. In addition, limited term employees have substantially less tenure protection than permanent or probationary employees.

### Temporary Authorization Appointment (TAU)

A Temporary Authorization appointment (TAU) is an appointment made in the absence of an appropriate employment list and cannot exceed nine months in any 12 consecutive month periods. The nine-month period may be computed on a calendar or actual time worked (ATW) basis. ATW is defined as 194 days in twelve consecutive months. Per State Personnel Board interpretation, employees in the Graduate Student Assistant, Student Assistant, and Youth Aide classes may work on an actual hours worked basis to a maximum of 1,500 hours in a 12 consecutive month period regardless of the number of days they have worked.

A temporary appointee shall not acquire any probationary or permanent status and time spent under temporary appointment shall **not** contribute to the probationary period if the appointee is subsequently successful in an examination and is certified and appointed to the position.

### Retired Annuitant (RA)

A retired annuitant, as defined by Government Code Section 20012, is a former employee of either the State or other public agency that contracts with the Public Employees Retirement System (PERS) and who is receiving a retirement allowance. However, only a former employee of a State agency may be appointed.

Retired employees can be hired temporarily without a reinstatement from retirement or loss of or interruption of benefits. Retired employees who are appointed under these conditions are called Retired Annuitants.

### Length of appointment for RAs

Retired annuitants should be considered for short term intermittent or temporary work. This hiring option provides an experienced employee who can assume the full range of duties with no training.

A retired employee may be employed (without reduction in retirement benefits) for no more than 960 hours per fiscal year (July – June).

# Tenure *Continue*

### Career Executive Assignments (C.E.A.)

CEAs are State employees in high-level managerial positions. CEA employees:

- Develop and implement policy
- May serve in a department Director's cabinet or from a department's executive staff
- Serve at the top levels in a department (first or second levels for small departments, top three for medium-sized departments, top four for large departments

### Emergency Appointment

Emergency appointments allow the appointing powers (DGS) to hire staff for short periods without respect to employment lists to:

- Respond to true emergencies such as fire or flood
- Perform unusual, short duration work (30 days or less) or
- Fill temporary vacancies (20 to 60 days) in established positions in accordance to State Personnel Board rules

# Time Base

Time base designates the amount of work time to which the employee is appointed and entitled to receive compensation. The employee must have eligibility to the time base of the position which he/she is transferring to or applying for.

**Full-Time**

Is an appointment in which the employee is to work the amount of time required for the employee to be compensated at a full time rate.

**Part-Time**

Is an appointment where the employee is to work a specific fraction of the full time schedule. The employees are paid on a negative payroll but work in a part time basis; 1/2, 3/4, 4/5, as well as other fractional time bases. The number of hours required to work for each pay period is based on the fraction assigned to the employee's position.

**Intermittent**

Intermittent time base is irregular or recurring hourly employment that is less than full time. It is used to provide a trained workforce available on an "on-call" basis. Intermittent employee's tenure may be TAU, LT or permanent.

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# Reinstatements

This Manual Section

- Identifies the different types of reinstatements
- Provides information regarding the reinstatement process
- Describes the Attendance Clerk's responsibilities when an employee is reinstating or is exercising his/her return rights to a position in their prior classification

This section contains the following topics:


| Topic | See Page |
|---|---|
| Mandatory Reinstatement | 14 |
| Permissive Reinstatement | 15 |
| Reinstatement from Military Leave | 16 |
| C.E.A. Reinstatement Rights | 16 |


In order to be reinstated to a full-time position, the applicant must have had prior employment on a full-time permanent basis in the class (or related class) to which he/she wants reinstatement.

An applicant whose prior employment was on a full-time basis may be considered for full-time, part-time or intermittent work.

A permanent intermittent or part-time employee who has not been appointed on a full-time basis prior to his/her resignation may be considered only for either intermittent or part-time employment.

# Types of Reinstatements

**Mandatory reinstatement**

A mandatory reinstatement right entitles the employee to return to his/her former position with all of the status and rights that he/she had before vacating it. To have mandatory reinstatement rights, the employee must be in a circumstance covered by a reinstatement statute and meet all of the legal requirements specified for that particular type of reinstatement (e.g., prior status in general civil service).

Mandatory Reinstatement applies only to a permanent employee, or an employee who previously had permanent status and who, since receiving permanent status, had no break in service due to a permanent separation. Mandatory reinstatement applies to employees who are:

- Employees returning form training and development assignments, terminated from a temporary or a limited term appointment with prior permanent civil service status;
- Rejected during probation, with prior permanent civil service status;
- Demoted from a managerial position provided all of the conditions required are met

Mandatory Reinstatement also applies to permanent employees who are returning from an approved leave of absence. These special leave types are as follows:

- Leave of Absence
- Non-Industrial Leave
- Worker’s Compensation
- Military Leave

**Mandatory reinstatement after a Leave of Absence**

The employee has absolute right of return to his/her former classification in the same geographical location after a leave of absence. However, the employee may request reinstatement in a different location, reporting unit or section. At the department’s discretion, this written request should be submitted through the appropriate channels to OHR.

# Reinstatements *Continue*

### Permissive reinstatement

Permissive reinstatement is a privilege and not a mandatory right, which allows a former employee the opportunity to be re-employed without having to re-compete in an examination. An eligible person may reinstate with any department to his/her former classification, a lower class in the same series, or to other class to which the employee could transfer or demote in accordance with CalHR rule.

An appointing power, (DGS) may, in its discretion, reinstate any person having probationary or permanent status who has separated from his or her position by:

- Voluntary resignation
- Service retirement
- Termination from a limited – term appointment, temporary, C.E.A. or exempt appointment
- Lay off
- Demoted in lieu of layoff
- Automatic resignation

### Employee responsibilities

Because a permissive reinstatement is a privilege and not a mandatory right, it is necessary for an individual seeking reinstatement to locate a vacancy and apply for the position. CalHR does not provide a listing of vacant positions and it is not possible to place the person's name on any eligible list. However, a person may access CalHR's website for a complete listing of vacancies by visiting: www.calhr.ca.gov

### Attendance Clerk responsibilities

When an employee is reinstating or exercising his/her right of return to a position in their prior classification, the Attendance Clerk must do the following:

| If employee is returning after | AC must notify the PS. | ABMS entry required? | RPA required? |
|---|---|---|---|
| Leave of Absence (LOA) | Yes | No | No |
| Rejection on Probation | Yes | Yes | Yes |
| Worker's Compensation | Yes | No | No |
| Military Leave | Yes | No | No |
| Resignation or service retirement | Yes | Yes | Yes |
| Termination of a Limited Term, Temporary or C.E.A. appointment | Yes | Yes | Yes |

# Reinstatements *Continue*

### Reinstatement from Military Leave

Following the completion of military leave the employee must contact their supervisor and their Personnel Office upon release from active duty to request reinstatement. The table below identifies the time limits for reinstatement:

| Employee Status | Military Leave Type | Length of Military Leave | Time Limits for Reinstatement |
|---|---|---|---|
| Limited Term or Temporary | Short term | 30 days or less | 10 calendar days or within 30 days after any rehabilitation period |
| | | 30 days not to exceed 180 days | 14 calendar days or within 30 days after any rehabilitation period |
| Permanent or Probationary | | Less than 30 days up to 180 days | 14 calendar days following any rehabilitation period |
| Permanent, Probationary or Exempt | Long term | 6 months not to exceed 5 years | 6 months |
| Limited Term or Temporary | Emergency | Various | 10 calendar days or 30 calendar days after the end of the State military emergency ordered by the Governor |
| Permanent or Probationary | | Various | 14 calendar days or 30 calendar days after the end of the State military emergency ordered by the Governor |

### C.E.A. reinstatement rights

An employee terminated from a C.E.A. shall be reinstated to his or her former position unless the employee elects to be appointed to another position, offered by the appointing power, for which the employee is eligible.

Employee's will either (1) have no prior permanent civil service status; or (2) have prior civil service permanent status and since that status have had a break in service due to a permanent separation, is entitled to return to their former position.

C.E.A. return rights are dependent upon the length of State service, length of C.E.A. service, and departmental vacancy status. An incumbent that is terminated from a C.E.A. must request reinstatement within 10 calendar days of the date of the termination notice.

# Appointment Process

This Manual Section

- Explains the appointment process
- Identifies the Attendance Clerk's responsibilities in the appointment process

This section contains the following topics:


| Topic | See Page |
|---|---|
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| Pre-Employment Guide | 19 |
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| Dependent Eligibility Verification Checklist | 103 |

# Appointment Process

The Appointment Process is the method used to fill vacant positions. A Request for Personnel Action (RPA) is initiated by your office's Personnel Liaison and approved by the Classification and Pay Analyst in the Office of Human Resources assigned to your unit.

### Attendance Clerk responsibility

Once approval is received from the Classification and Pay (C/P) Analyst, your responsibilities will be to coordinate the **Pre-Employment Package** and **Date of Appointment Package** the employee is required to complete.

You will forward both packages within each of their time frames to your Personnel Specialist (PS) in the Personnel Transactions Unit (PTU) in the Office of Human Resources (OHR). Refer to Pre-Employment Documents and Date of Appointment Documents for guidelines on completing each required form.

| Pre-Employment | Date Of Appointment |
|---|---|
| • Provide the employee with the Pre-Employment documents and advise that the documents must be completed in ink.<br>• Review all documents for thoroughness, accuracy and clarity.<br>• If Medical Examination Report is required, make appointment for employee with the designated physician. (The physician will forward the Medical Examination to your PS.)<br>• Submit the Pre-Employment Package with all original documents signed and completed to your PS prior to the employee's first day of work. | • Complete the Appointment Document Checklist (DGS OHR 70).<br><br>https://www.apps.dgs.ca.gov/StatewideFormsWeb/Forms.aspx<br><br>• Provide the employee with the required appointment documents and have her/him complete the documents either in ink or typed.<br>• Review all documents for thoroughness, accuracy and clarity.<br>• Before submitting the completed Date of Appointment Package to PTU:<br>o If employee is new to State service or a transfer from another agency, enter new employee into ABMS through Quick Employee Entry.<br>o If employee transfers within DGS and supervisor of employee has changed, enter correct supervisor into PAL.<br>• Submit the Date of Appointment Package with all original documents signed and completed to your PS within 5 working days after the effective date of appointment. |

# DGS Pre-Employment Guide

Employees who are responsible for maintaining records that contain personal information shall take all necessary precautions to protect the confidentiality of records containing personal information and to assure such records are not disclosed to unauthorized individuals or entities.

The Pre-Employment Document Samples and Guidelines section includes samples of the documents, an overview of each form, where to obtain the forms and Instructions on completing the required documents needed to appoint the employee.

The forms are samples only and shall not be reproduced. It is recommended Attendance Clerks keep a supply of forms. PTU does not provide copies.

The guidelines are intended for use under normal operating circumstances. Other circumstances may arise that, in management's judgment, require a different approach. We reserve the right to take a different course when we believe it to be appropriate.

**Purpose**

The purpose of pre-employment clearance documents is to ensure that all appointees to and employees in the State civil service shall possess the general qualifications of integrity, honesty, sobriety, dependability, industry, thoroughness, accuracy, good judgment, initiative, resourcefulness, courtesy, ability to work cooperatively with others, willingness and ability to assume the responsibilities and to conform to the conditions of work characteristic of the employment, and a state of health, consistent with the ability to perform the assigned duties of the class.

The Pre-Employment Package must be approved and submitted to PTU prior to the employee's first day of work. Failure to obtain the approvals may result in an illegal appointment.

# DGS Pre-Employment Guide *Continue*

**Appointment Document Checklist**

The Appointment Document Checklist (DGS OHR-70) is a two-sided document you may use as a guideline while coordinating required **Pre-Employment** and **Date of Appointment** documents for the employee to complete depending on the appointment type.

The completed Appointment Package must be submitted to PTU within 5 working days after the employee's date of hire. A delay in submission may delay the employee receiving a pay warrant and benefits.

**Requirements**

The Appointment Package consists of the Date of Appointment Document Checklist and the required documents needed to process the employee's appointment.

The Appointment Checklist is required for:

- New hires to State service
- Reinstatements from permanent separations
- Transfers from another State agency
- Intradepartmental transfer within DGS when there is a position number change

# DGS Pre-Employment Guide *Continue*

## Sample of DGS OHR 70 (Front)

CLEAR | PRINT | SAVE

STATE OF CALIFORNIA
APPOINTMENT DOCUMENT CHECKLIST
DGS OHR 70 (Rev. 04/16)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

CONFIDENTIAL: This document contains personal information and Pursuant to Civil Code 1798.21
It shall be kept confidential in order to protect against unauthorized disclosure.

**REFER TO THE INSTRUCTIONS BELOW FOR GUIDELINES AND DOCUMENT DEADLINES**
(Check the appropriate box when you complete each form)

| EMPLOYEE (Last, First, Middle Initial) | ABMS NUMBER | RPA NUMBER | APPOINTMENT EFFECTIVE DATE |
|---|---|---|---|
| | | | |

| POSITION NUMBER | CE | EMPLOYEE'S SUPERVISOR (Last, First, Middle Initial) |
|---|---|---|
| | | |

SAMPLE

The Attendance Clerk is responsible for completing the appointment document checklist. It is required for ALL appointment types (including transfers within the same office) and is due to your OHR Specialist within **5 working days after the employee's date of hire.**
***NOTE:*** Verify Social Security Number, completion of; Employment Eligibility Verification Form I-9, Statement of Economic Interest Form 700 (if applicable), Essential Functions Health Questionnaire (STD 910), Medical Examination (STD 610) and Hire above Minimum Authorizations (DGS OHR 906) must be submitted and approved **PRIOR** to the employee's first day of work.

**☐ NEW HIRE**
**☐ REINSTATEMENT FROM PERMANENT SEPARATION**

- ☐ ABMS – KEY EMPLOYEE IN QUICK EMPLOYEE ENTRY
- ☐ ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE (STD 910) / MEDICAL EXAMINATION (STD 610) / Date Submitted:
- ☐ EMPLOYMENT ELIGIBILITY VERIFICATION (I-9)
- ☐ VERIFY SOCIAL SECURITY NUMBER
- ☐ APPLICATION (STD 678)
- ☐ EMPLOYEE ACTION REQUEST (STD 686)
- ☐ OATH OF ALLEGIANCE (STD 689)
- ☐ OATH OF OFFICE (STD 688) *(Exempt appointments only)*
- ☐ STATE EMPLOYEE RACE/ETHNICITY QUESTIONNAIRE (CalHR 1070)
- ☐ EMPLOYEE STATE DISABILITY QUESTIONNAIRE (Online SPB – 131 Voluntary)
- ☐ CALPERS MEMBER RECIPRICOL SELF-CERTIFICATION FORM (PERS-CASD-801)
- ☐ STATEMENT OF ECONOMIC INTEREST (FORM 700) *(if applicable)*
- ☐ DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANT (STD 243)
- ☐ EMERGENCY INFORMATION/PHYSICIAN DESIGNATION (DGS OHR 20)
- ☐ INCOMPATIBLE ACTIVITIES STATEMENT
- ☐ MILITARY SERVICE INFORMATION (STD 912)
- ☐ EMPLOYEE ASBESTOS NOTIFICATION (STD 250) *(if applicable)*
- ☐ DGS' ANTI-DISCRIMINATION POLICY (AO 15-01)
- ☐ DGS' SEXUAL HARASSMENT MEMO (AO 15-02)
- ☐ UNION INFORMATION PACKAGE *(if applicable)*

**☐ TRANSFER WITHIN DGS**

- ☐ APPLICATION (STD 678)
- ☐ ABMS – KEY EMPLOYEE'S SUPERVISOR *(if applicable)*
- ☐ EMPLOYEE ASBESTOS NOTIFICATION (STD 250) *(if applicable)*
- ☐ STATEMENT OF ECONOMIC INTEREST (FORM 700) *(if applicable)*
- ☐ OATH OF OFFICE (STD 688) *(Exempt appointments only)*
- ☐ DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANT (STD 243)
- ☐ UNION INFORMATION PACKAGE *(if applicable)*

**☐ TRANSFER FROM ANOTHER STATE AGENCY**

- ☐ ABMS – KEY EMPLOYEE IN QUICK EMPLOYEE ENTRY
- ☐ APPLICATION (STD 678)
- ☐ EMPLOYEE ASBESTOS NOTIFICATION (STD 250) *(if applicable)*
- ☐ STATEMENT OF ECONOMIC INTEREST (FORM 700) *(if applicable)*
- ☐ DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANT (STD 243)
- ☐ EMERGENCY INFORMATION/PHYSICIAN DESIGNATION (DGS OHR 20)
- ☐ INCOMPATIBLE ACTIVITIES STATEMENT
- ☐ OATH OF OFFICE (STD 688) *(Exempt appointments only)*
- ☐ DGS' ANTI-DISCRIMINATION POLICY (AO 15-01)
- ☐ DGS' SEXUAL HARASSMENT MEMO (AO 15-02)
- ☐ UNION INFORMATION PACKAGE *(if applicable)*

**DOCUMENTS LISTED BELOW MUST BE RECEIVED IN PTU BY DEADLINES TO ENSURE EMPLOYEE'S BENEFITS ARE EFFECTIVE TIMELY**
**Days noted are counted from effective date of appointment (check appropriate boxes below when you have provided this information to the employee).**

| Start date | Start date | 120 days |
|---|---|---|
| ☐ NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE NOTICE | ☐ DEPENDENT ELIGIBILITY VERIFICATION CHECKLIST (CalHR 781) | ☐ ELECTION OF OPTIONAL MEMBERSHIP *(Exempt employee only)* |
| ☐ SUMMARY OF BENEFITS AND COVERAGE NOTICE | ☐ PREMIER VISION PLAN (CalHR 774) | ☐ PST RETIREMENT BOOKLET |
| ☐ ACA NOTIFICATION CHECKLIST (CalHR 782) *(Provide within 14 days of hire date)* | ☐ ANNUAL LEAVE PROGRAM PACKAGE | ☐ RETIREMENT BOOKLET (TIER 1/TIER 2) |
| ☐ HEALTH BENEFITS PACKAGE (HBD-12) | ☐ LIFE INSURANCE (STD 698) *(Excluded employee only)* | |
| ☐ DECLARATION OF HEALTH COVERAGE (HB-12A) | ☐ LONG TERM DISABILITY (GR-1153-1) *(Excluded employee only)* | |
| ☐ DENTAL PLAN PACKAGE (STD 692) | ☐ GROUP LEGAL SERVICES INSURANCE | |
| ☐ FLEXELECT FORM (STD 701R) OR (STD 701C) | | |
| ☐ CONSOLIDATED BENEFITS (COBEN) CASH ENROLLMENT ELECTION (STD 702) | | |

| ATTENDANCE CLERK SIGNATURE: | DATE: |
|---|---|
| SIGN HERE | |

# DGS Pre-Employment Guide *Continue*

## Sample of DGS OHR 70 (Back)

STATE OF CALIFORNIA
APPOINTMENT DOCUMENT CHECKLIST
DGS OHR 70 (Rev. 04/16)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

**CONFIDENTIAL: This document contains personal information and Pursuant to Civil Code 1798.21 It shall be kept confidential in order to protect against unauthorized disclosure.**

SAMPLE

| FORM | New to State Service | Reinstatement | Transfer to DGS | Transfer within DGS | INFORMATION/DEADLINE FOR SUBMISSION (If noted, form is due with appointment package) |
|---|---|---|---|---|---|
| VERIFICATION OF SOCIAL SECURITY NUMBER **(Pre-Employment)** | X | X | | | If the employee does not provide a social security card access the Social Security Number Verification System online: https://www.ssa.gov/employer/ssnv.htm |
| ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE (STD 910) **(Pre-employme** | X | X | X | X | Must be received in PTU prior to appointment or within 5 days of start date. |
| MEDICAL EXAMINATION (STD 610) **(Pre-Employment)** | X | X | *X | X | ***Only if the class requires a medical exam. Must be approved by the SPB Medical Officer prior to employee's start date.** |
| EMPLOYEE ELIGIBILITY VERIFCATION (I-9) **(Pre-Employment)** | *X | X | | | *New employees **will not** be allowed to work until I-9 has been received in PTU. |
| HIRE ABOVE MINIMUM REQUEST (DGS OHR 906) **(Pre-employment)** | X | X | | | Only if requesting to offer incumbent a salary that exceeds the minimum of the class. Must be approved by OHR Chief prior to making a commitment to the employee. |
| ABMS<br>1. QUICK EMPLOYEE ENTRY<br>2. CHANGE EMPLOYEE'S SUPERVISOR | X | X | X | X | 1. Must be done before submitting appointment package to PTU.<br>2. If employee's supervisor has changed. |
| APPLICATION (STD 678) | X | X | X | X | Must be submitted with appointment package (With the exception of POST and BID) |
| EMPLOYEE ACTION REQUEST EAR (STD 686) | X | X | OPTIONAL | OPTIONAL | Option for transfers if employee's information has changed. |
| OATH OF ALLIGIANCE (STD 689) | X | X | | | |
| OATH OF OFFICE (STD 688) | *X | *X | *X | *X | *EXEMPT APPOINTMENTS ONLY. |
| STATE EMPLOYEE RACE/ETHNICITY QUESTIONNAIRE (CalHR -1070) | X | X | | | • Employee's response is voluntary.<br>• Employee chooses not to self-identify, department is required to visually identify. |
| EMPLOYEE STATE DISABILITY QUESTIONNAIRE (Online SPB – 131 Voluntary) | X | | | | Must inform the new to State employees and current employees who have a status change that the survey is now available online from any computer. |
| CALPERS MEMBER RECIPRICOL SELF-CERTIFICATION FORM (PERS-CASD-801) | X | X | | | |
| STATEMENT OF ECONOMIC INTEREST (FORM 700) **(Pre-Employment)** | *X | *X | *X | *X | *Required for classifications designated under DGS Conflict of Interest Code. |
| DESIGNATION OF PERSON AUTHORIZED TO RECEIVE WARRANTS (STD 243) | X | X | OPTIONAL | OPTIONAL | *Optional for transfers if employee information is changing. |
| EMERGENCY INFORMATION/PHYSICIAN DESIGNATION (DGS OHR 20) | X | X | X | | |
| INCOMPATIBLE ACTIVITIES STATEMENT | X | X | X | | |
| MILITARY SERVICE DECLARATION | X | X | | | |
| DGS ANTI-DISCRIMINATION POLICY | X | X | X | | |
| DGS SEXUAL HARASSMENT MEMO | X | X | X | | |
| EMPLOYEE ASBESTOS NOTIFICATION (STD 250) | X | X | X | X | Required for employees working in a building containing asbestos. |
| UNION INFORMATION PACKAGE | *X | *X | *X | *X | *Check in this box denotes the employee was given Union package, check MOU's |
| NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE NOTICE | X | X | | | Required for new employees regardless of their health plan enrollment or eligibility status, within 14 days of the employee's hire date. |
| SUMMARY OF BENEFITS AND COVERAGE NOTICE/ACA NOTIFICATION CHECKLIST (CalHR 782) | X | X | | | • Employees who average 130 hours of service per month.<br>• Must be given to every new employee within 14 hire or become eligible. |
| HEALTH BENEFITS (HBD-12) AND DECLARATION OF HEALTH BENEFITS (HB-12A) | X | X | | | • Time base of half time or more<br>• Both forms must be submitted together<br>• Must be received in PTU within 15 days of appointment date. |
| DENTAL PLAN PACKAGE (STD 692) | X | X | *X | *X | *May be required if employee is changing CBID. Must be received in PTU within 15 days of appointment. |
| FLEX ELECT PLAN BROCHURE | X | X | | | • Must be received in PTU within 15 days of appointment.<br>• Cash option is only option available to PI employees. |
| CONSOLIDATED BENEFITS (COBEN) CASH ENROLLMENT ELECTION (STD 702) | X | X | | | |
| DEPENDENT ELIGIBILITY VERIFICATION CHECKLIST (CalHR 781) | X | X | | | Must be submitted with HBD 12/12A, and STD 692 when adding dependents. |
| PREMIER VISION PLAN | X | X | | | |
| ANNUAL LEAVE PROGRAM | *X | *X | *X | *X | *Check MOU's for eligibility. |
| LIFE INSURANCE (STD 698) | X | X | X | X | • Automatic enrollment for non-represented employees with permanent tenure.<br>• Employee must complete if declining enrollment |
| LONG TERM DISABILITY (GR-1153-1) | X | X | X | X | • Non-represented employees with permanent tenure.<br>• Received in PTU within 15 days of appointment. |
| GROUP LEGAL SERVICES INSURANCE | X | X | X | X | • PI employees are eligible to enroll.<br>• Received in PTU within 15 days of appointment of eligible employees. |
| RETIREMENT BOOKLET-ACKNOWLEDGEMENT (TIER 1/TIER 2) | X | X | X | X | • Received in PTU within 120 days of appointment date.<br>• Permanent tenure is required. |
| PST RETIREMENT BOOKLET | X | X | | | • Part time, seasonal, temporary.<br>• Received in PTU within 120 days of appointment date. |
| ELECTION OF OPTIONAL MEMBERSHIP | X | X | X | X | • Exempt employees appointed by the Governor. |

# DGS Pre-Employment Package

### DGS Policy

It is the policy of the DGS, in accordance with State civil service laws, rules, and policies, to require completion and submission of pre-employment clearance documents prior to the effective date of appointment (acceptance of a job offer and prior to first day of work).

### The Pre-Employment Package

The following table identifies the documents required *prior* to an employee's first day on the job:

YES: Required NO: Not Required Asterisk (*): See Comments

| Appointment Document/ Form Number | New to State Service | Reinstatement | Transfer from Other State Agency | Transfer Within DGS | Comments |
|---|---|---|---|---|---|
| Verify Social Security Number | YES | NO | NO | NO | https://www.ssa.gov/employer/ssnv.htm |
| Employment Eligibility Verification Form I-9 | YES* | YES* | NO | NO | EE will not be allowed to work until I-9 received http://www.uscis.gov/files/form/i-9.pdf |
| Health Questionnaire (STD 910) | YES* | YES* | YES* | YES* | EE will not be allowed to work until form is received and approved; required for all classes including those classes that require a medical examination. |
| Medical Examination, with physicians report (STD 610) | YES* | YES* | YES* | YES* | EE will not be allowed to work until form is received and approved; refer to Medical Clearance section of this manual for a list of classes requiring a medical examination. |
| Conflict of Interest Form 700 | YES* | YES* | YES* | YES* | Prior to appointment for designated positions, it is suggested that the form be completed at the time of the job offer to ensure the potential employee complies with the requirement of the position. If the employee declines to comply with the requirements of the position, the second best qualified candidate may be offered the position. Form 700 is dependent on the type of hire. |
| Hire Above Minimum Request (HAM) OHR -906 | YES* | YES* | YES* | YES* | Your assigned OHR Personnel Analyst must approve the HAM prior to committing to the candidate. It cannot be requested and approved after a candidate accepts employment. (If applicable) |

# Verification of Social Security Number

The Attendance Clerk (AC) is responsible for verifying the Social Security Numbers of all employees hired new to State Service. Verification of the Social Security number is completed only if an employee does not provide a social security card. Verification must be conducted prior to the verification of the I-9. This is critical to ensure the employee is eligible to work in the State of California and to ensure we do not make illegal hires.

The AC will access the Social Security Number Verification System (SSNVS) by going online to register for authorization at the following website:

https://www.ssa.gov/employer/ssnv.htm

It will provide instructions to register staff in the SSNVS.

***Important: Remember, the SSN is CONFIDENTIAL and it is not to be shared or sent through email.***

**Registration Process**

- Once on the website, click on "register" button
- Read the User Registration Attestation, then click on the "I accept" button
- Create a login by completing all the fields with Personal information, then click "next"
- Create your password, the password must be exactly 8 characters and must contain at least one letter and one number

  ***Note:** do not use your registration identification or your employer identification number (EIN). This is your own personal password.*
- Complete all five security questions then click "next"
- Review your account information to ensure everything is correct and certify the information by clicking "I accept" then "submit"
- Print your User ID and click "next"
- Check the box that says "SSA Services Suite for Employers" then click "next"
- Click on the link to "add your employer information"
- Scroll to the bottom of the page and click "I accept" this will take you to the page to add your EIN
- Check the circle for "I have an SSN and I am an employee of a business or organization that has an EIN"
- In Employer Identification Number (EIN) box enter 946001347
- Click "Look-Up Name
- Click "Submit Employer Information"
- To verify the SSNVS you will require an Activation Code, which you will receive form the Transaction Analyst. This takes approximately two to three weeks to receive
- When activation code is received, the AC will go login to the SSNVS at https://www.ssa.gov/employer/ssnv.htmClick on the "Log in" button. Complete user ID and password

  ***Note: Activation code is only valid for 10 days so it is vital that you log into the SSNVS as soon as possible and activate your account.***
- Read user certification, check the box certifying that you have read and agree to the terms, then, click on the "Log in' button. This will take you to the main menu where you will select "Enter Activation Code"
- Enter the activation code in the box and click on the "Activate Services" button. You will receive a confirmation informing you that "You have successfully activated SSNVS"
- "Go to the Mani Menu" button, this will take you where you can click on "Social Security Number Verification Service"

# Verification of Social Security Number *Continue*

**Registration Process** Continue

- Select from the following actions:
  - Request Online SSN Verification
  - Submit an Electronic File for SSN Verification
  - View Status and Retrieval Information
  - View Social Security Number Verification Service
- Select View Social Security Number Verification Service Handbook, this will allow you to review additional information on submitting files to Social Security for verification and retrieving the results of the submissions

User ID(s) and password(s) are confidential and are **not to be shared**. Only authorization individuals may register and use this system.

For security purposes passwords must be changed every 90 days by logging into the SSNVS and clicking on "Change password" button, you will then type in the following:

- Enter current password
- Enter new password
- Confirm new password

Go to the bottom of the page and click "Change Password" button. Once this is done you will receive a message stating "Your password has been successfully changed". Your password will remain valid until the date specify.

**Verify New To State Employee's Social Security Number**

The AC will access the SSNVS by going online https://www.ssa.gov/employer/ssnv.htm
Complete user ID and password.

You will be asked to provide the Employer's Name and Identification Number (State controller, State of California – 946001347), then you will be asked to provide the following:

- Social Security Number
- First name, middle name (if applicable), last name, suffix
- Date of birth
- Gender

When verification is complete the system will allow you to print the verification page. Print the verification page and forward it with your new hire package to your Personnel Specialist. Verifying the social security number is required prior to the employee's state date.

***Important: Remember, the SSN is CONFIDENTIAL and is not to be shared or sent through email.***

# Federal Employment Eligibility Verification (I-9)

The US Immigration Reform and Control Act (IRCA) of 1986 states that employers should hire U.S. citizens or aliens authorized to work in the United States. The law requires employers to verify employment eligibility of all persons hired. The Form I-9 is a Federal Immigration and Naturalization form and is available in English (I-9) and in Spanish (I-9).

A new employee will not be allowed to work until PTU has received the completed I-9 Form.
Mandatory procedure the employer must follow:

| Required: | Not Required: |
|---|---|
| • All new hires to State service | • Transfers from another State agency |
| • Permissive reinstatements | • Mandatory reinstatements (e.g., return from NDI leave ) |
| • Retired Annuitants | • Promotions |
| | • Demotion |

**Attendance Clerk responsibilities**

The Form I-9 is part of the Pre-Employment Package. It shall not be completed until after a commitment to the employee has been made and before the employee's *first day* of actual work.

The original Form I-9 is filed in the employee's OPF in a sealed envelope.

# Federal Employment Eligibility Verification (I-9) *Continue*

## Sample of I-9

**Employment Eligibility Verification**

**Department of Homeland Security**
U.S. Citizenship and Immigration Services

**USCIS**
**Form I-9**
OMB No. 1615-0047
Expires 03/31/2016

**►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.**
**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

| Last Name *(Family Name)* | First Name *(Given Name)* | Middle Initial | Other Names Used *(if any)* |
|---|---|---|---|
| | | | |

| Address *(Street Number and Name)* | Apt. Number | City or Town | State | Zip Code |
|---|---|---|---|---|
| | | | | |

| Date of Birth *(mm/dd/yyyy)* | U.S. Social Security Number | E-Mail Address | Telephone Number |
|---|---|---|---|
| | - - | | |

SAMPLE

**I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.**

**I attest, under penalty of perjury, that I am (check one of the following):**

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

**3-D Barcode**
**Do Not Write In This Space**

| Signature of Employee: | Date *(mm/dd/yyyy)*: |
|---|---|
| | |

**Preparer and/or Translator Certification** *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

**I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.**

| Signature of Preparer or Translator: | Date *(mm/dd/yyyy)*: |
|---|---|
| | |

| Last Name *(Family Name)* | First Name *(Given Name)* |
|---|---|
| | |

| Address *(Street Number and Name)* | City or Town | State | Zip Code |
|---|---|---|---|
| | | | |

STOP *Employer Completes Next Page* STOP

Form I-9 03/08/13 N — Page 7 of 9

# Federal Employment Eligibility Verification (I-9) *Continue*

**Sample of I-9** Continue

## Section 2. Employer or Authorized Representative Review and Verification

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)*

**Employee Last Name, First Name and Middle Initial from Section 1:**

| List A<br>Identity and Employment Authorization | OR | List B<br>Identity | AND | List C<br>Employment Authorization |
|---|---|---|---|---|
| Document Title: | | Document Title: | | Document Title: |
| Issuing Authority: | | Issuing Authority: | | Issuing Authority: |
| Document Number: | | Document Number: | | Document Number: |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: | | Expiration Date *(if any)(mm/dd/yyyy)*: |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | | | |
| Document Title: | | | | |
| Issuing Authority: | | | | |
| Document Number: | | | | |
| Expiration Date *(if any)(mm/dd/yyyy)*: | | | | |

SAMPLE

**3-D Barcode**
**Do Not Write In This Space**

### Certification

**I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.**

**The employee's first day of employment *(mm/dd/yyyy)*: _____ *(See instructions for exemptions.)***

| Signature of Employer or Authorized Representative | Date *(mm/dd/yyyy)* | Title of Employer or Authorized Representative | |
|---|---|---|---|
| Last Name *(Family Name)* | First Name *(Given Name)* | Employer's Business or Organization Name | |
| Employer's Business or Organization Address *(Street Number and Name)* | City or Town | State | Zip Code |

## Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

| A. New Name *(if applicable)* Last Name *(Family Name)* | First Name *(Given Name)* | Middle Initial | B. Date of Rehire *(if applicable) (mm/dd/yyyy)*: |
|---|---|---|---|

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

| Document Title: | Document Number: | Expiration Date *(if any)(mm/dd/yyyy)*: |
|---|---|---|

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

| Signature of Employer or Authorized Representative: | Date *(mm/dd/yyyy)*: | Print Name of Employer or Authorized Representative: |
|---|---|---|

Form I-9 03/08/13 N

Page 8 of 9

# Federal Employment Eligibility Verification (I-9) *Continue*

**LISTS OF ACCEPTABLE DOCUMENTS**
**All documents must be UNEXPIRED**

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

| LIST A<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>Documents that Establish Employment Authorization |
|---|---|---|---|---|
| 1. U.S. Passport or U.S. Passport Card | | 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | 1. A Social Security Account Number card, unless the card includes one of the following restrictions:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION |
| 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address | | 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | | 3. School ID card with a photograph | | 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| 4. Employment Authorization Document that contains a photograph (Form I-766) | | 4. Voter's registration card | | 4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:<br>a. Foreign passport; and<br>b. Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | 5. U.S. Military card or draft record | | 5. Native American tribal document |
| | | 6. Military dependent's ID card | | 6. U.S. Citizen ID Card (Form I-197) |
| | | 7. U.S. Coast Guard Merchant Mariner Card | | 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | 8. Native American tribal document | | 8. Employment authorization document issued by the Department of Homeland Security |
| | | 9. Driver's license issued by a Canadian government authority | | |
| 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | | **For persons under age 18 who are unable to present a document listed above:** | | |
| | | 10. School record or report card | | |
| | | 11. Clinic, doctor, or hospital record | | |
| | | 12. Day-care or nursery school record | | |

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.**

***NOTE:*** *Examine* ***one*** *document from "list A"* ***OR*** *examine a combination of one document from* *each* ***"list B AND list C".***

# Federal Employment Eligibility Verification (I-9) *Continue*

**Completion of I-9 Form**

The I-9 is a five part document which consists of the following:

1. Instructions on I-9 completion
2. Updating, Filing Fee, Form Information, Photocopying/Retention Information and Privacy Act Information
3. Paperwork Reduction Act Information
4. Form I-9
5. List of Acceptable Documents (for Identification Purposes)

The Form I-9 contains two sections. The employee will complete Section 1 and provide required original document(s) to establish identity and employment eligibility. You may complete Section 2 and verify documents for authenticity and validity.
It may be typed or use a ballpoint pen. Do not use a pencil.

Refer to List of Acceptable Documents for Form I- 9 Verification, for examples of acceptable documents for I-9 purposes. The employee must present either:

- One document from List A

**OR**

- One document from List B and one document from List C.

ALL documents must be UNEXPIRED. In some instances, a document that appears to be expired may be acceptable if the expiration date shown on the face of the document has been extended.

Submit original Form I-9 with copies of attachments to your PS with the Pre-Employment Package.

# Federal Employment Eligibility Verification (I-9) *Continue*

## Completion of I-9 Form

<table>
<tr><th>Employee</th><th>Attendance Clerk</th></tr>
<tr><td rowspan="2">Complete Section 1 and provide:<br><br>• Name<br><br>• Other Name Used (if applicable)<br><br>• Street Address, City, State and Zip Code<br><br>• Date of Birth<br><br>• Social Security Number<br><br>• Email Address and Phone number (Optional)<br><br>• Citizen Information: employee must check one of the four boxes identifying residential status in the United States.<br><br>• Employee’s signature<br><br>• Date</td><td>Complete Section 2, Employer Review and Verification.<br><br>Employee must present one document from List A OR one document from List B AND one document from List C<br><br>Do not specify which document(s) the employee may present form the list.<br><br>• Verify the validity of the document.<br><br>If there are expiration dates on the original document, temporary license, or a receipt from Social Security Administration, you shall:<br><br>- Make a note to check for renewed identification, original driver’s License or Social Security Card.<br>- Note on original Form I-9 a corrected I-9 shall be forthcoming.<br><br>• Enter the employees first day of employment.<br>• Sign and date the certification as the Authorized Representative for the employer.<br>• Employers Business or Organization Name and Address, City, State, Zip Code.<br>• Photocopy employee’s identification papers and attach to original Form I-9.<br>• Submit original Form I-9 with attachments to your PS with the Pre-Employment Package.<br><br>The person who examines the documents must be the same person who signs section 2. The examiner and the employee must be both present during the examination of documents.</td></tr>
<tr><td>Complete Section 3 Updating and Re-verification.<br><br>Enter the following if updating or re-verifying:<br><br>• Name: First, Middle Initial<br>• Date of Rehire: Month/Day/Year<br>• New or updated document authorizing person to work<br><br>➢ Document Title<br>➢ Document #<br>➢ Expiration Date (if any)<br><br>• Signature and Date</td></tr>
<tr><td>Preparer and /or Translator Certification<br><br>• Signature<br>• Print Name<br>• Street Address<br>• Date/sign</td><td></td></tr>
</table>

# Federal Employment Eligibility Verification (I-9) *Continue*

**Updating the I-9 Form**

The form I-9 must be updated whenever:

- A receipt from the Social Security Administration is presented in lieu of an actual Social Security card. The employee is allowed 21 days to present original Social Security card.

- A Temporary Driver's License has been used to identify employee. The employee shall be advised to provide the original upon receipt, usually within 60 days.

- The employees' employment eligibility documents expire. Example of such documents: foreign passport, INS employment authorizations and reentry permits.

When the employee has provided the necessary document(s) required for updating the Form I-9, you may review for validity. If it appears to be genuine, complete a new I-9 noting that it has been updated and copy required documents. The updated Form I-9 and copies of required documents is forwarded to PTU.

# Medical Clearances

### Medical Clearance (1 of 2) Essential Functions Health Questionnaire (Std. 910) and Health Questionnaire (STD 610)

The Americans with Disabilities Act (ADA), in compliance with AB 2222, requires state departments to provide reasonable accommodation to individuals with a medical condition. Therefore, it is necessary for duty statements to identify and describe the essential functions, required knowledge, skills, and abilities, and work environment for all positions. “Essential functions” refer to the basic job duties of the position that the incumbent must be able to perform with, or without, reasonable accommodation.

#### Requirements

Before an employee may begin the duties of a civil service position, certain conditions of employment must be met. One of the requirements of employment is a medical clearance. There are two types of medical clearances:

- Essential Functions Health Questionnaire STD 910
- Health Questionnaire (with Physician's Report) STD 610
  (**Only Required for Certain Classifications**)

Health questionnaires are mandatory and must be completed and submitted. The STD 610 must be **approved prior to appointment.**

When making a firm job offer, the hiring supervisor shall provide the prospective employee with a copy of the Essential Functions Health Questionnaire (STD. 910) **and/or** the Health Questionnaire with Physician's Report (STD 610 if applicable) along with the Physical Requirements of Position form and Essential Functions Duty Statement, when a **firm** job offer is made. The Medical Clearance must be approved in advance of the appointment.

* The prospective employee must be advised not to terminate their current employment or make a change in their residence until their Health Questionnaire or Medical Clearance is approved.

Completion of the STD 910 and/or STD 610 is **mandatory** if the classification the applicant is applying for requires the Health Questionnaire STD 610, then it is part of the Pre-Employment package.

# Medical Clearances *Continue*

**Sample of Health Questionnaire STD 910 (Front)**
**Form is available at:** www.osp.dgs.ca.gov.

Print Clear

STD. 910 (EST. 1/2002) (FRONT)

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

## ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE

### *APPLICANT INFORMATION*

| LAST NAME | FIRST NAME | SOCIAL SECURITY NUMBER | GENDER ☐ MALE ☐ FEMALE |
|---|---|---|---|
| ADDRESS | | CITY | STATE / ZIP CODE |
| DAYTIME TELEPHONE / EVENING TELEPHONE | CLASSIFICATION | HIRING DEPARTMENT | |

### *CONTACT INFORMATION*

| NAME | TITLE |
|---|---|
| LOCATION | TELEPHONE |

### *LIST OF ESSENTIAL FUNCTIONS*

*Enter list of essential functions of the job from current duty statement here, or attach duty statement:*

**SAMPLE**

### *ACKNOWLEDGEMENT*

*I certify that the duties listed above represent the essential functions of the job and classification listed above.*

| SUPERVISOR'S NAME | SUPERVISOR'S SIGNATURE | DATE |
|---|---|---|
| PERSONNEL OFFICER'S NAME | PERSONNEL OFFICER'S SIGNATURE | DATE |

# Medical Clearance *Continue*

## Sample of Health Questionnaire STD 910 (Back)

STD. 910 (EST. 1/2002) (BACK)

**ESSENTIAL FUNCTIONS HEALTH QUESTIONNAIRE**

STATE OF CALIFORNIA
STATE PERSONNEL BOARD

***APPLICANT'S CERTIFICATION OF ESSENTIAL FUNCTIONS***

*I certify that I have read the essential functions of the job listed on page 1 and considering my current health status (please check one of the boxes below):*

- ☐ I am able to perform all of the essential functions of the job without a need for reasonable accommodation.
- ☐ I am able to perform all of the essential functions of the job, but will require reasonable accommodation (please describe your requested accommodation in the Reasonable Accommodation section below).
- ☐ I am unable to perform one or more of the essential functions of the job, even with reasonable accommodation.
- ☐ I am not sure if I am able to perform one or more of the essential functions of the job. I have identified the functional limitations that I believe may limit my ability to perform the essential functions of the job in the Request for Essential Functions Evaluation section below.

***REASONABLE ACCOMMODATION (If necessary, you may attach additional pages)***

*For each essential function of the job for which you require reasonable accommodation, please describe the reasonable accommodation you are requesting:*

**SAMPLE**

***REQUEST FOR ESSENTIAL FUNCTIONS EVALUATION (If necessary, you may attach additional pages)***

*I am not sure whether I have a physical or mental limitation that may prevent or otherwise impair me from performing the essential functions of the job. Below I have listed the essential functions in question and my specific functional limitations that I believe may prevent or otherwise impair me from performing the listed essential functions of the job. I authorize the hiring authority, if necessary, to refer this information to the State Personnel Board's Medical Officer, or his/her delegate, to determine my ability to perform the essential functions of the job with or without reasonable accommodation.*

***ACKNOWLEDGEMENT***

*I certify that the information I have provided concerning my ability to perform the essential functions of the job is true and complete to the best of my knowledge.*

| APPLICANT'S NAME *(Print or type)* | APPLICANT'S SIGNATURE | DATE |
|---|---|---|
| | | |

# Medical Clearances *Continue*

## Completing the Essential Functions Health Questionnaire (STD 910)

| Attendance Clerk Completes the: | Applicant / Employee Completes the: |
|---|---|
| • Applicant Information<br>o Enter Applicants name, social security number, gender, address, telephone numbers, classification and department name. | • Applicant's Certification of Essential Functions<br>o Applicant will check the applicable box. |
| • Contact Information<br>o Enter the applicable information. | • Reasonable Accommodation<br>o Applicant lists a reasonable accommodation for each essential function they are requesting. If applicable. |
| • List of Essential Functions<br>o Enter list of functions on the job from the current duty statement or attach it. | • Request for Essential Functions Evaluation<br>o If the applicant is unsure if they have a physical or mental limitation for any of the essential functions, they are to be listed within this section for authorization for the hiring authority to refer to CalHR to determine if the essential function can be performed with or without reasonable accommodation. |
| • Acknowledgement<br>o Supervisor will print his/her name, sign and date.<br>o Personnel Officer will print name, sign then date. | • Acknowledgment<br>o Applicant will print his/her name, sign and date |

# Medical Clearances *Continue*

**List of Classifications that Require STD 610**

The following table lists the various classifications that require a STD 610, based on language contained in the classification specification, in alphabetical order.

**List of classes**

| Class Title | Class Code |
|---|---|
| Assistant Chief, BPM | 6666 |
| Assistant Civil Engineer | 3126 |
| Associate Civil Engineer | 3123 |
| Associate Industrial Engineer | 3584 |
| Associate Industrial Hygienist | 3856 |
| Associate Mechanical Engineer | 3582 |
| Automobile Mechanic | 6851 |
| Automotive Pool Attendant I | 6898 |
| Automotive Pool Attendant II | 6897 |
| Automotive Pool Attendant III | 6894 |
| Associate Printing Plant Superintendent | 7222 |
| Bookbinder I | 7404 |
| Bookbinder II | 7402 |
| Bookbinder III | 7401 |
| Bookbinder IV | 7399 |
| Building Maintenance Worker | 6215 |
| Carpenter I | 6476 |
| Carpenter II | 6475 |
| Carpenter Supervisor | 6470 |
| Chief Engineer I | 6698 |
| Chief Engineer II | 6695 |
| Construction Inspector I | 4033 |
| Construction Inspector II | 4032 |
| Construction Supervisor I | 4031 |
| Construction Supervisor II | 4030 |
| Construction Supervisor III | 4029 |
| Custodian | 2011 |
| Custodian Supervisor II | 2002 |
| Custodian Supervisor III | 2001 |
| Digital Composition Specialist I | 7255 |
| Digital Composition Specialist II | 7256 |
| Digital Composition Specialist III | 7258 |
| Digital Print Operator I | 1411 |

# Medical Clearances *Continue*

**List of Classifications that Require STD 610** Continue

**List of classes** (continued)

| Class Title | Class Code |
|---|---|
| Digital Print Operator II | 1412 |
| Direct Construction Supervisor I | 4036 |
| Direct Construction Supervisor II | 4038 |
| Direct Construction Supervisor III | 4045 |
| District Structural Engineer | 3332 |
| Electrical Engineer[1] | 3613 |
| Electrical Inspector II | 4034 |
| Electrician I | 6533 |
| Electrician II | 6532 |
| Electrician Supervisor | 6530 |
| Electronics Technician | 6913 |
| Elevator Operator | 2034 |
| Fire & Life Safety Officer I | 4348 |
| Fire & Life Safety Officer II | 4351 |
| Groundskeeper | 0731 |
| Hearing Reporter | 1229 |
| Heavy Equipment Mechanic | 6834 |
| Heavy Truck Driver | 6378 |
| Inspector of Automotive Equipment | 6892 |
| Interagency Messenger | 1697 |
| Junior Inspector of Automotive Equipment | 6871 |
| Laborer | 6223 |
| Lead Automobile Mechanic | 6850 |
| Lead Custodian | 2003 |
| Lead Groundskeeper | 0725 |
| Lithographic Platemaker | 7325 |
| Locksmith I | 6642 |
| Mailing Machines Operator I | 1779 |
| Mailing Machines Operator II | 1780 |
| Mailing Machines Supervisor I | 1459 |
| Maintenance Mechanic | 6940 |
| Maintenance and Service Occupational Trainee | 9992 |
| Materials and Stores Specialist | 1506 |
| Materials and Stores Supervisor | 1503 |
| Mechanical Engineer | 3583 |
| Mechanical Inspector II | 4037 |
| Mechanic's Helper | 6837 |

# Medical Clearances *Continue*

**List of Classifications that Require STD 610** Continue

**List of classes** (continued)

| Class Title | Class Code |
|---|---|
| Mechanical and Technical Occupational Trainee | 9993 |
| Office Building Manager I | 6675 |
| Office Building Manager II | 6673 |
| Office Building Manager III | 6672 |
| Office Building Manager IV | 6671 |
| Office Machine Service Technician | 6782 |
| Office Machine Service Technician (Electronic) | 6797 |
| Office Machine Service Technician Trainee | 6785 |
| Offset Press Assistant | 7335 |
| Painter I | 6526 |
| Painter II | 6525 |
| Painter Supervisor | 6520 |
| Plumber I | 6549 |
| Plumber II | 6548 |
| Plumber Supervisor | 6543 |
| Principal Structural Engineer | 3330 |
| Printing Plant Machinist | 7431 |
| Printing Trades Assistant I | 7438 |
| Printing Trades Assistant II | 7437 |
| Printing Trades Specialist II (General) | 1499 |
| Printing Trades Specialist Trainee (General) | 1485 |
| Restoration Supervisor I | 6644 |
| Restoration Supervisor II | 6647 |
| Restoration Work Specialist | 6648 |
| Restoration Worker | 6651 |
| Senior Civil Engineer | 3120 |
| Senior Electrical Engineer | 3600 |
| Senior Equipment Material Specialist | 1542 |
| Senior Landscape Architect | 3983 |
| Senior Inspector of Automotive Equipment | 6855 |
| Senior Mechanical Engineer | 3579 |
| Senior Telecommunications Technician | 6910 |
| Service Assistant – Automotive | 6917 |
| Service Assistant (Duplicating) | 1484 |
| Service Assistant – Maintenance | 9994 |
| Service Assistant – Warehouse and Stores | 1510 |
| Sheetfed Offset Press Operator I | 7327 |

# Medical Clearances *Continue*

**List of Classifications that Require STD 610** Continue

**List of classes** (continued)

| Class Title | Class Code |
|---|---|
| Sheetfed Offset Press Operator II | 7324 |
| Sheetfed Offset Press Operator III | 7330 |
| Sheetfed Offset Press Operator IV | 7329 |
| Skilled Laborer | 6212 |
| Stationary Engineer | 6712 |
| Stationary Engineer Apprentice (Four-Year Program) | 6717 |
| Stock Clerk | 1509 |
| Supervising Groundskeeper I | 0719 |
| Supervising Groundskeeper II | 0717 |
| Supervising Structural Engineer | 3331 |
| Supervising Telephone Operator | 1625 |
| Supervisor of Building Trades | 6753 |
| Telecommunications Maintenance Supervisor I | 6909 |
| Telecommunications Technician | 6911 |
| Telecommunications Technician Trainee | 6912 |
| Tree Maintenance Leadworker | 0745 |
| Tree Maintenance Worker | 0748 |
| Truck Driver | 6381 |
| Warehouse Manager II | 1500 |
| Warehouse Worker | 6220 |
| Webfed Offset Press Operator II | 7331 |
| Webfed Offset Press Operator III | 7332 |
| Webfed Offset Press Operator IV | 7333 |
| Window Cleaner | 2037 |

# Medical Clearances *Continue*

## Medical Clearance (2 of 2)

**Sample of Health Questionnaire (with Physician's Report) STD 610 Page 1**
**Form is available at:** www.osp.dgs.ca.gov.

Print Clear

STATE OF CALIFORNIA – STATE PERSONNEL BOARD
**HEALTH QUESTIONNAIRE**
**(With Physician's Report)**
STD. 610 (REV. 6/2009) (Page 1 of 4)

STATE LAW AND THE AMERICANS WITH DISABILITIES ACT REQUIRE APPLICANTS TO FILL IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM **ONLY AFTER A JOB OFFER HAS BEEN MADE**

DATE JOB OFFER MADE

SOCIAL SECURITY NUMBER (Optional - See Privacy Statement below.)

**THIS AREA TO BE COMPLETED BY HIRING AGENCY — COMPLETED QUESTIONNAIRE WILL BE RETURNED TO HIRING AGENCY**

APPLICANT NAME (Last) (First) (Middle)

HIRING AGENCY NAME

APPLICANT ADDRESS (Number and Street) (City) (State) (ZIP Code)

AGENCY ADDRESS

CLASS TITLE AND POSITION NUMBER OF VACANCY

HIRING MANAGER'S NAME AND TELEPHONE NUMBER

APPOINTMENT TYPE
☐ PERMANENT ☐ TAU ☐ LIMITED TERM
(If reinstatement, enter dates of previous State employment.)
☐ REINSTATEMENT

DESIRED APPOINTMENT DATE

CERTIFICATION NUMBER

CURRENT OCCUPATION

**THIS AREA TO BE COMPLETED BY THE APPLICANT**

**DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.**
Your answers to the following questions will be evaluated in connection with the performance of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1–43 be explained in the space provided on the back of this form.

SAMPLE

BIRTH DATE ☐ FEMALE ☐ MALE HEIGHT WEIGHT

For questions 1–31, have you ever had or do you have the following:

| ITEM | YES | NO |
|---|---|---|
| 1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma | | |
| 2. Residuals of poliomyelitis | | |
| 3. Hepatitis, jaundice, or other liver ailments | | |
| 4. Cancer, malignant tumor, or cysts | | |
| 5. Diabetes or sugar in urine | | |
| 6. Pernicious anemia, leukemia, or other blood disorder or ailment | | |
| 7. Mental illness | | |
| 8. Any disorder of the nervous system | | |
| 9. Seizure disorder or loss of consciousness | | |
| 10. Severe headaches or migraine | | |
| 11. Heart trouble--including circulatory disease | | |
| 12. Rheumatic fever | | |
| 13. Any defect of bones or joints, including amputations, dislocations, or broken bones | | |
| 14. Rheumatism, arthritis, or bursitis | | |
| 15. Back pain or back injury | | |
| 16. Head injury | | |
| 17. Any problems with hips, knees, ankles, or feet | | |
| 18. Any problems with hands, elbows, or shoulders | | |
| 19. Fainting spells or dizziness | | |
| 20. Skin rash from work | | |
| 21. Allergies | | |
| 22. Sensitivity to dust or smoke | | |
| 23. High or low blood pressure | | |
| 24. Varicose veins | | |
| 25. Stomach or duodenal ulcer or other bowel problem | | |
| 26. Rupture or hernia | | |

| ITEM | YES | NO |
|---|---|---|
| 27. Gall bladder trouble | | |
| 28. Kidney or bladder trouble | | |
| 29. Shortness of breath | | |
| 30. Any speech impairment | | |
| 31. History of addiction to drugs or alcohol | | |
| 32. Do you wear or have you ever worn glasses? | | |
| 33. Do you or have you ever worn contact lenses? | | |
| 34. Have you had any eye injury, surgery, or disease? | | |
| 35. Are you blind in one eye? | | |
| 36. Are you blind in both eyes? | | |
| 37. Do you wear a hearing aid or have you had at any time a problem with your hearing? | | |
| 38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2. | | |
| 39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address. | | |
| 40. Are you taking any medication now or in the last 12 months? If yes, what? | | |
| 41. Have you ever been hospitalized? If yes, list reason and date of hospitalization. | | |
| 42. a. Have you had an illness or injury which caused you to lose time from work? | | |
| b. Does this illness or injury continue to limit your ability to perform certain types of work? | | |
| 43. Have you ever had any other illness, injury or physical condition not named above (exclude minor problems such as colds, flu, etc.)? | | |

CONFIDENTIAL

(Continue on reverse.)

**PRIVACY NOTICE**

**Official Responsible**: Medical Officer, State Personnel Board, 801 Capitol Mall, Sacramento, CA 95814-4806; **Authority**: Government Code Section 18931; **Purpose**: The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; **Providing Information**: Medical clearance is required prior to employment in State service; **Effects of Not Providing Information**: Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous. A misrepresentation or omission may be cause for adverse employment action; **Access**: Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

# Medical Clearance *Continue*

Medical Clearance (2 of 2)

**Sample of Health Questionnaire (with Physician's Report) STD 610 Page 2**

STATE OF CALIFORNIA — STATE PERSONNEL BOARD

**HEALTH QUESTIONNAIRE**
**(With Physician's Report)**

STD. 610 (REV. 6/2009) (Page 2 of 4)

Please write your own account and your own evaluation of all items to which you have answered "YES" to the prior questions. Include DATE OF ONSET, YOUR PRESENT CONDITION AS YOU EVALUATE IT and what accommodations to your limitations, if any, you feel you may require to perform satisfactorily the duties of the position for which you are applying without endangering the health and safety of yourself or others. **Return this completed form to the hiring agency unless (1) advised otherwise by the hiring agency, or (2) if you prefer, send it directly to the Medical Officer, State Personnel Board, 801 Capitol Mall, Sacramento, CA 95814-4806. If you choose the latter, be sure to notify the hiring agency you have done so.**

SAMPLE

| NAMES OF DOCTORS WHO WERE CONSULTED FOR TREATMENT OF CONDITION DESCRIBED ABOVE | DOCTORS' ADDRESSES | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| **CERTIFICATION:** I certify that I have provided true and complete information concerning my fitness. (Any misrepresentation or material omission may be cause for dismissal.) | APPLICANT'S SIGNATURE | DATE SIGNED | TELEPHONE NUMBER |

**APPLICANT — DO NOT WRITE BELOW THIS LINE— DELEGATED AUTHORITY OR STATE PERSONNEL BOARD MEDICAL OFFICER ONLY**

REVIEWER

☐ **APPROVED** ☐ **Subject to Proper Placement (STPP)** ☐ **DISAPPROVED**

IF DISAPPROVED, STATE JOB-RELATED RATIONALE; IF STPP, STATE RESTRICTIONS

| REVIEWING AUTHORITY'S SIGNATURE | DATE SIGNED | TELEPHONE NUMBER |
|---|---|---|
| REVIEWING AUTHORITY'S NAME (Typed or printed) | | |

# Medical Clearance *Continue*

## Medical Clearance (2 of 2)

**Sample of Health Questionnaire (with Physician's Report) STD 610 Page 3**

STATE OF CALIFORNIA – STATE PERSONNEL BOARD

**HEALTH QUESTIONNAIRE**
**(With Physician's Report)**
STD. 610 (REV. 6/2009) (Page 3 of 4)

**(To be completed by a licensed physician and surgeon only after a job offer has been made)**

**TO THE PHYSICIAN:** The attached Health Questionnaire must be completed and submitted to you by the person whose name appears below. It is intended to assist you in conduct of the examination. You are requested to complete the medical examination report. **The Hiring Agency is responsible for payment of the fee.** See page 4 for instructions.

APPLICANT'S SOCIAL SECURITY NUMBER (Optional)

**ALL ITEMS BELOW ARE MANDATORY--COMPLETED REPORT SHOULD BE RETURNED TO HIRING AGENCY**

APPLICANT'S NAME (Last) (First) (Middle)

HIRING AGENCY NAME

APPLICANT'S ADDRESS (Number and Street) (City) (State) (ZIP Code)

AGENCY ADDRESS

CLASS TITLE AND POSITION NUMBER OF VACANCY

HIRING MANAGER'S NAME AND TELEPHONE NUMBER

APPOINTMENT TYPE
☐ PERMANENT ☐ TAU ☐ LIMITED TERM ☐ PEACE OFFICER
(If reinstatement, enter dates of previous State employment.)
☐ REINSTATEMENT

DESIRED APPOINTMENT DATE

CERTIFICATION NUMBER

CURRENT OCCUPATION

**DOCTOR:** Write comments on any positive or negative findings for evaluation of applicant.(If more space is needed, use reverse of this form and/or a separate sheet of paper.) Examine color vision only when required in Minimum Qualifications.

1. HEIGHT

2. VISION
☐ GLASSES ☐ CONTACT LENSES

2A. COLOR VISION TESTING REQUIRED
☐ NO ☐ NORMAL ☐ ABNORMAL ☐ ISHIHARA

WEIGHT(Without heavy clothing or shoes)

| | UNCORRECTED | | CORRECTED | | 3. HEARING (Ordinary conversation at 10 feet considered normal) | | AUDIOMETRY (If done) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NEAR | DISTANT | NEAR | DISTANT | RIGHT | LEFT | | 500 | 1000 | 2000 | 3000 | 4000 |
| Right 20/ | | | | | | | | | | | | |
| Left 20/ | | | | | / 15 | / 15 | Right | | | | | |
| Both 20/ | | | | | HEARING AID USED ☐ YES ☐ NO | | Left | | | | | |

SAMPLE

4. HEAD (Eyes, ears, nose, mouth, throat)

5.(A) RESTING PULSE RATE

5.(B) BLOOD PRESSURE

6. LUNGS (Breath sounds, rales)

7. HEART (enlargement, rhythm, sounds) AND CIRCULATORY SYSTEM

8. NERVOUS SYSTEM (Reflexes, motor strength, atrophy, sensory changes, or any abnormal reflexes)

9. ABDOMEN (G.I. system, liver, spleen, masses, scars, hernias, etc.)

HERNIA

10. GENITOURINARY SYSTEM INCLUDING KIDNEYS

11. RECTAL
Fissure | Fistual | Hemorrhoids

12. SPINE (Deformity, tenderness, range of motion)

13. EXTREMITIES (Strength, range of motion, deformities, atrophy or sensory changes)

14. SKIN AND LYMPHATICS, SIGNIFICANT SCARRING

15. VARICOSE VEINS (Severity)

16. URINALYSIS
Specific Gravity | Albumin | Sugar

17. ANY WORK LIMITATION (Specify)

18. PSYCHIATRIC EVALUATION (Any mental disorder observed)

19. PHYSICIAN'S SIGNATURE (Required)

PHYSICIAN'S NAME AND ADDRESS - (Required - Please print)

TELEPHONE NUMBER (Required )

DATE SIGNED

PHYSICIAN'S TAXPAYER I. D. NUMBER (FEIN or SSA number - Required)

# Medical Clearance *Continue*

Medical Clearance (2 of 2)
**Sample of Health Questionnaire (with Physician's Report) STD 610 Page 4**

STATE OF CALIFORNIA– STATE PERSONNEL BOARD
**HEALTH QUESTIONNAIRE**
**(With Physician's Report)**
STD. 610 (REV. 6/2009) (Page 4 of 4)

## NOTICE TO PHYSICIANS AND CLINICS

The State of California requires preplacement physical examinations for certain classes of employment. The State also has many employees who are required to have a physical examination at the time of renewal of their Class I or II driver's license, when the possession of the license is required for the position.

**SAMPLE**

**If the hiring agency is not identified, do not perform the examination.** The State Personnel Board does not have the authority to perform examinations.

## REPORTS

The medical report should be sent to the Hiring Agency shown on Page 1, unless you are requested by the person examined to mail this medical report directly to the State Personnel Board Medical Office, 801 Capitol Mall, Sacramento, California 95814-4806.

## BILLINGS

**Please send your bill for this examination to the Hiring Agency as indicated on Page 1.** Include your Federal Employer Identification Number or Social Security Number for tax reporting purposes.

The State Hiring Agency will pay the fee for this Medical Examination Report up to a maximum determined by the Department of Health Services and set forth in the State Administrative Manual (Section 0190.1). The current fee allowance may be obtained from the Hiring Agency shown on Page 1. If there should be additional studies or examinations required for more complete evaluation of the individual, these examinations will be at the expense of the applicant.

# Medical Clearance *Continue*

**Completing the Health Questionnaire (with Physician's Report) STD 610**

The Medical Examination Report (STD.610) is a four-page form completed by the Attendance Clerk, employee and physician designated by the Department who provides the examination.

Medical Examination Report is required for classifications that require an approved medical examination as a condition of employment. Refer to DGS' Department Pay Scales to determine if the classification requires a Medical Examination. The Footnote * (asterisk) will designate those classifications.

It is crucial that the required sections are completed accurately and deadlines met to expedite the Medical Clearance Process. The PL and/or AC will forward the original Medical Examination to CalHR to the Medical Officer for approval and will notify the OHR Transaction Manager when the approval is received. It is part of the Pre-employment package and shall not be held for submission with the Date of Appointment Checklist.

# Medical Clearance *Continue*

Do not use a pencil when completing the form.

<table>
<tr><th>Attendance Clerk</th><th>Employee</th></tr>
<tr><td rowspan="3">Schedule medical examination with designated physician.<br><br>Advise the employee not to terminate their current employment or make a change in residence until approval is received.<br><br>Complete the Hiring Agency Section on Pages 1, 2 & 3<br><br><u>IMPORTANT!</u> Include the RPA number and the Agency/Unit on top of the document.<br><br>• Date job offer made<br>• Applicant’s Social Security Number<br>• Applicant’s name and address (<u>also enter on page 3</u>)<br>• Class title (<u>also enter on page 3 along with the position number</u>)<br>• Check box for appropriate appointment type (<u>also enter on page 3</u>)<br>• Desired appointment date (<u>also enter on page 3</u>)<br>• Certification number (the Personnel Liaison will be able to provide from the RPA)<br>• Current occupation<br>• Agency name: (<u>also enter on page 3</u>)<br>➢ Department of General Services (Followed by your office or client agency in parentheses)<br>• Agency address: (<u>also enter on page 3</u>)<br>➢ The Ziggurat, 707 Third Street, Suite 7-130 West Sacramento, CA 95605 ATTENTION: Enter your PSS’ name<br>➢ Telephone number: Enter your PSS’ phone number</td><td>Employee shall complete the applicant’s area:<br><br>• Birthdate<br>• Male/Female<br>• Height and weight<br>• Complete items 1-43<br>• Any “yes” questions answers must be explained on Page 2<br>• Applicant’s signature in the two signature boxes<br>• Date signed<br>• Telephone number<br><br>Employee will take the Medical Examination Report to the examination.</td></tr>
<tr><td>Designated Physician</td></tr>
<tr><td>The physician designated by the Department will complete page 3 by:<br><br>• Completing items 1- 19<br>• Sign name in item 19<br>• <u>REQUIRED:</u> print name, address, telephone number<br>• Physician’s taxpayer ID number<br>• Date signed</td></tr>
</table>

# Statement of Economic Interest (Form 700)

The Department of General Services (DGS) is required by the Fair Political Practice Commission (FPPC) to maintain a Conflict of Interest Code. The Conflict of Interest Code includes employee positions that involve the making or participation in the making of decisions that may foreseeably have a material effect on any financial interest, as set forth in subdivision (a) of section 87302 of the Government Code. The FPPC prohibits officials at all levels from acting on matters in which they have an economic interest. Public officials must disclose investments, interests in businesses and realty, and income which might be affected by their official actions.

**Types of Filing**

DGS employees in positions that are covered by the DGS Conflict of Interest Code are required to file; 1) newly appointed official or newly employed in a designated position, 2) an annual Statement of Economic Interests (Form 700) each calendar year covering the period of January 1st - December 31st, 3) when an official/employee leaves office; generally, the period covered is January 1, 20xx, (the calendar year the employee just completed) through the date the employee stopped performing the duties of their position.

All DGS employees are responsible for reviewing the DGS Conflict of Interest Code and determining whether their position is listed in the Conflict of Interest Code and, if so, the disclosure category to which their position is assigned.

For the full text of DGS' current Conflict of Interest Code, including which positions are required to file Form 700s and their disclosure categories, please refer to OHR's Personnel Operations Manual at the following link:
http://www.documents.dgs.ca.gov/ohr/pom/CIPositions.pdf .

An employee in a newly created position that participates in the making of decisions and whose specific position is not yet listed in an agency's conflict-of-interest code is required to file a Form 700 unless the department determines otherwise in writing.

Forms must be submitted timely to allow sufficient time for DGS internal reviews and to avoid any FPPC fines that MAY apply to late submissions.

- The employee has 30 days from the date they assume and/or leave office to complete and return the Form 700.
- Late statements are subject to a late fine of $10 per day per position up to $100 for each day the statement is late.

An amendment to a Form 700 may be filed at any time – there is no deadline. A Filer may submit more than one amendment.

Refer to the FPPC's web site for information regarding the Fair Political Practices Act:
http://www.fppc.ca.gov/

# Statement of Economic Interest (Form 700) *Continue*

**Attendance Clerk responsibilities**

The completed form must be signed and forwarded to the employees Supervisor. After the review of supervisors, the Personnel Liaisons will forward these forms to the AC and then will be forwarded to the Conflict of Interest Filing Officer for review. The original report will be filed in the employee's OPF, and a copy in the Conflict of Interest Binder for public inspection.

**Completing the Statement of Economic Interest Form 700**

| **Personal Information** | **Enter employee's**:<br>Full legal name |
|---|---|
| **#1 Office, Agency, or Court (Do not use Acronyms)** | • **Agency:** *(e.g.,* Department of General Services)<br>• **Division, Board, District:** your office's name (e.g., Office of Procurement)<br>• **Your Position***:* position title **If Filing For Multiple Positions:** employee shall complete if necessary. |
| **#2 Office Jurisdiction** | • Check the box "State" |
| **#3 Type of Statement** | • **Assuming Office/Initial:** check this box<br>• **Date:** employee's date of appointment |
| **#4 Schedule Summary** | **Employee:** will check the appropriate box(es) for Schedule(s) attached and list the total number of pages submitted (including the cover page).<br><br>**Note: If no Schedules are attached, list the total number of pages submitted as "1" and check the "None" box. Do not advise the employee on completing this section.** |
| **#5. Verification** | • **Mailing address:** work address is preferred, but home address will be acceptable.<br>• **Daytime phone number**: Location where employee may be reached during the day if the statement is questioned.<br>• **Workplace e-mail**<br><br>**Employee shall date and sign the verification.** |

# Statement of Economic Interest (Form 700) *Continue*

**Sample of Statement of Economic Interest Form 700**
**Form is available at: http://www.fppc.ca.gov**

CALIFORNIA FORM 700
FAIR POLITICAL PRACTICES COMMISSION
A PUBLIC DOCUMENT

STATEMENT OF ECONOMIC INTERESTS

COVER PAGE

Date Received
Official Use Only

*Please type or print in ink.*

NAME OF FILER (LAST) (FIRST) (MIDDLE)

**1. Office, Agency, or Court**

Agency Name

Division, Board, Department, District, if applicable Your Position

SAMPLE

► If filing for multiple positions, list below or on an attachment.

Agency: _____ Position: _____

**2. Jurisdiction of Office** *(Check at least one box)*

☐ State
☐ Multi-County _____
☐ City of _____
☐ Judge (Statewide Jurisdiction)
☐ County of _____
☐ Other _____

**3. Type of Statement** *(Check at least one box)*

☐ **Annual:** The period covered is January 1, 2010, through December 31, 2010.

-or-

The period covered is ____/____/____, through December 31, 2010.

☐ **Assuming Office:** Date ____/____/____

☐ **Candidate:** Election Year _____ Office sought, if different than Part 1: _____

☐ **Leaving Office:** Date Left ____/____/____
*(Check one)*

○ The period covered is January 1, 2010, through the date of leaving office.

○ The period covered is ____/____/____, through the date of leaving office.

**4. Schedule Summary**

*Check applicable schedules or "None."*

► **Total number of pages including this cover page:** _____

☐ **Schedule A-1** - *Investments* – schedule attached
☐ **Schedule A-2** - *Investments* – schedule attached
☐ **Schedule B** - *Real Property* – schedule attached
☐ **Schedule C** - *Income, Loans, & Business Positions* – schedule attached
☐ **Schedule D** - *Income – Gifts* – schedule attached
☐ **Schedule E** - *Income – Gifts – Travel Payments* – schedule attached

-or-

☐ **None** - *No reportable interests on any schedule*

**5. Verification**

MAILING ADDRESS STREET CITY STATE ZIP CODE
*(Business or Agency Address Recommended - Public Document)*

DAYTIME TELEPHONE NUMBER ( ) E-MAIL ADDRESS

I have used all reasonable diligence in preparing this statement. I have reviewed this statement and to the best of my knowledge the information contained herein and in any attached schedules is true and complete. I acknowledge this is a public document.

**I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.**

Date Signed _____ *(month, day, year)* Signature _____ *(File the originally signed statement with your filing official.)*

Clear Cover Page | Print Form | *specify pages to print*

FPPC Form 700 (2010/2011)
FPPC Toll-Free Helpline: 866/275-3772 www.fppc.ca.gov

# Hire Above the Minimum Request (HAM) OHR - 906

The Department of General Services (DGS) has delegated authority to approve Hire-Above-Minimum (HAM) requests and exceptions to the HAM criteria for extraordinary qualifications without prior review/approval by the California Department of Human Resources (CalHR), for all new State employees. DGS is still required to submit HAM approval for a current State employee to CalHR in all cases. All pay differentials (i.e., Recruitment and Retention, etc.) shall be included in the calculation for a HAM.

**Authority**

Government Code Section 19836 authorizes CalHR to allow payments above the minimum salary rate of a classification for the following reasons:

- To obtain a candidate with a specific extraordinary qualifications.
- Prospective candidate's current salary must be above the minimum rate.
- Recruitment difficulty.

**Warning**: A HAM salary rate cannot be requested after an applicant accepts the job offer. Your assigned OHR Personnel Analyst must approve the HAM prior to committing to the candidate.

The HAM is the responsibility of the Personnel Liaison within your office. Questions regarding the HAM shall be directed to your Personnel Analyst.

The HAM is included in the Pre-Employment Package.

# Hire Above the Minimum Request (HAM) OHR – 906 *Continue*

**Sample of OHR 906**
**Form is available at:** www.osp.dgs.ca.gov.

State of California
OHR 906 (Rev 10/05)

Department of General Services

**HIRE ABOVE MINIMUM (HAM) FOR EXTRAORDINARY QUALIFICATIONS DOCUMENTATION**
Authority: GC 15836

- ATTACH A COPY OF THE CANDIDATE'S SIGNED APPLICATION AND THE DUTY STATEMENT.
- THE PROPOSED SALARY MUST BE APPROVED BY THE PERSONNEL ANALYST PRIOR TO THE APPOINTMENT DATE.
- SEND THIS COMPLETED FORM AND ANY ATTACHMENTS TO:

OFFICE OF HUMAN RESOURCES
Attn: Norma Alarado
Mailing Address: PO Box 989052, West Sacramento, CA 95798-9052
Street Address: 707 Third Street, 7th Floor, West Sacramento, CA 95605 (IMS Z-1)

| | | | | | |
|---|---|---|---|---|---|
| REQUESTOR: | | DATE : | | RPA NUMBER: | - |
| BRANCH/OFFICE/CLIENT AGENCY NAME: | | LOCATION OF POSITION: | | POSITION NUMBER | |
| | | | | - - - - | |
| 1. NAME OF APPLICANT: | | 2. CLASS TITLE: | | | |
| 3. PROPOSED MONTHLY SALARY: | | ALTERNATE SALARY RANGE: | | | |
| 4. PROPOSED APPOINTMENT DATE: | | | | | |
| 5. PRESENT EMPLOYER: | | | | | |
| 6. PRESENT MONTHLY SALARY (Attach copies of current pay statement and prior year W-2): | $ | | | | |
| 7. CURRENT COMPETITIVE SALARY OFFER (Attach copy of current other offer): | $ | | | | |
| 8. EXTRAORDINARY QUALIFICATIONS | | | | | |
| a. EXTRAORDINARY EDUCATION: | | | | | |
| b. EXTRAORDINARY EXPERIENCE: | | | | | |
| 9. CONTRIBUTION TO DEPARTMENT - How does the employee's extraordinary qualifications contribute to the department? | | | | | |
| 10. RECRUITMENT DIFFICULTY | | | | | |
| a. SCORE IN EXAMINATION FOR CLASS IN #2 ABOVE: | | RANK ON CERTIFICATION: | | | |
| b. NUMBER OF ELIGIBLES ON CERTIFICATION: | | | | | |
| c. NUMBER OF CANDIDATES INVITED TO BE INTERVIEWED: | | NUMBER OF CANDIDATES WHO WERE INTERVIEWED: | | | |
| d. HOW IS THE PERSON SUPERIOR TO OTHERS INTERVIEWED? | | | | | |
| e. HOW DOES THIS INDIVIDUAL'S EXPERIENCE AND QUALIFICATIONS COMPARE TO EMPLOYEES IN THE SAME CLASS/SAME LOCATION? | | | | | |
| RECOMMENDATION OF PERSONNEL ANALYST | | | | | |
| ☐ APPROVED<br>☐ DISAPPROVED | REASON FOR DISAPPROVAL, OR APPROVAL OF RATE DIFFERENT THAN REQUESTED: | | | | |
| RATE APPROVED: | $ | STEP: | | ALTERNATE RANGE: | |
| PERSONNEL ANALYST SIGNATURE | | | | DATE | |

SAMPLE

# Prior to Start Date

Prior to the employee's state date *Supervisors and Managers* are to follow the process detailed below for every new employee hired.

*Note: Attendance Clerks may be delegated to assist the Supervisor and/or Manager in the process.*

**5 Days prior to Start Date:**

☐ Fill out the "New EE Information" form and give a copy to the Personnel Liaison and Attendance Clerk.

- Personnel Liaison will: create an RPA, set up a telephone, add the employee to the internal OHR phone number lists, email the BSO for a cubicle name sign (if applicable) and set up a computer and let the manager know the computer name (OHRSMFxxxxxx).

  **Note***: Supervisors/Managers: You will need to know the computer name in order to fill out the electronic "Employee Information – Account Request" form.*

☐ Provide a Copy of Employee's Application to Attendance Clerk.

- Attendance Clerk will enter information from the "New EE Information" form into ABMS-QEE-Quick Employee Entry. This will automatically generate an HR-1 (HR Security Profile Request)
  - For Employees who requires access to ABMS and/or PAL for their assigned duties to their Office/Branch and must have access to confidential HR Personnel data in order to perform legal, statutory and/or government duties.

☐ Fill out the electronic form "Employee Information – Account Request" located at this web address: http://inside.dgs.ca.gov/ets/Resources/Employee/NewEmp.aspx

- *This will allow the employee to connect to the network on their first day*.

☐ Fill out the "Access Card Request" form (if applicable) located on the OHR shared drive: S:\SUPPORT\FORMS\Access Card Request and submit it to the OBAS.

- *This will allow time for the OBAS to give us a working access card before the employee's first day.*

**2 Days prior to Start Date:**

☐ Pick up the New Hire Packet from the Attendance Clerk

**On the Start Date:**

☐ Give the Attendance Clerk the following documents:

- A list of all equipment given to the new employee (keys, cell phones, etc.)
- Signed Original HR-1 (if applicable) AC will give to PL for processing.

Please note that an HR1 is not required for employees that access PAL to enter their own time, or for supervisors to approve time. This access is applied automatically. For more information on PAL access, refer to the PAL website at: http://inside.dgs.ca.gov/pal/Tips/PALAccess.aspx.

# Prior to Start Date *Continue*

**Sample of New Employee Information Form**

## NEW EMPLOYEE INFORMATION

***Supervisors and Managers**: Turn this form in to the Personnel Liaison and Attendance Clerk 5 days prior to employee's start date.*

Employee Name_____

Supervisor's Name_____

Start Date_____

Date of Birth_____

SAMPLE

RPA Number_____

Position Number_____

Method of Appointment (lateral, list, etc.)_____

Tenure_____

Time Base_____

New Hire or Transfer_____
(If a transfer from other state agency include agency they are transferring from e.g. EDD, FTB, etc.)

Cubicle Number_____

Phone Number_____

Social Security Number_____

# New Employee Setup

### New Employee Login Authorization

In order for an employee to be able to log onto the DGS Network, a network account must be created. Additionally, a new e-mail account must be created for the employee. To have these accounts created, the new employee's supervisor must fill out and submit an **Employee Information - Account Request** form (use only the most recent version of the form - linked below).

You must allow a **minimum of five working days for the account to be created.** Best practice is to submit the form as soon as your new employee has accepted the job offer.

### Requesting Employee User Account

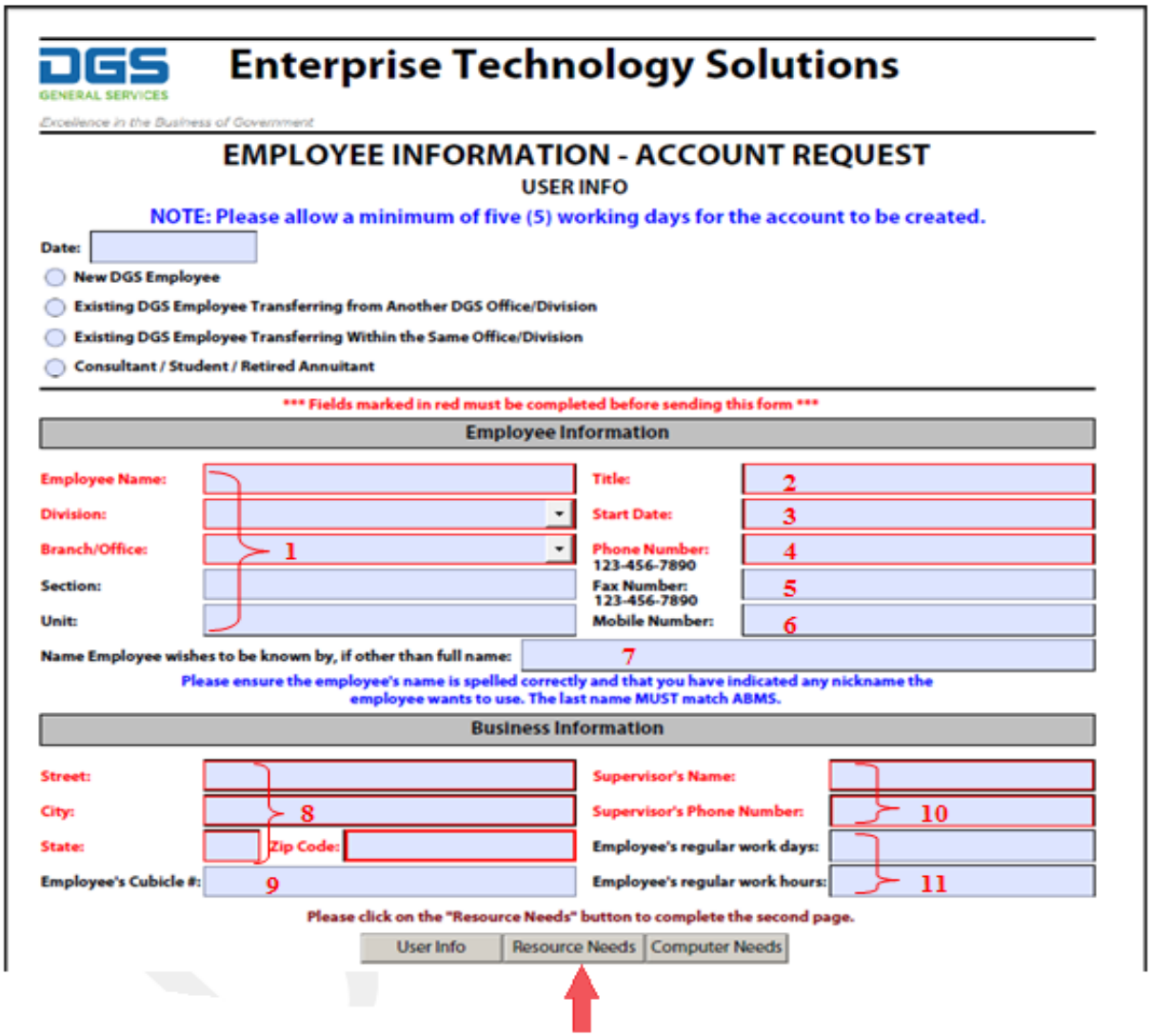
Use this form to request a new employee user account. This includes an employee new to the DGS, or one who is transferring from one division/office to another.
When the new employee's account is ready, an ETS technician will notify you and setup the user's profile on the computer(s) that he or she will be using.

EmployeeInformation-AccountRequest.pdf

If you have any additional questions, please contact the ETS Help Desk at (916) 375-4357 or e-mail them at ETSHelpDesk@dgs.ca.gov.

# New Employee Setup *Continue*

## Sample/Instructions of Employee Information – Account Request



DGS GENERAL SERVICES — Enterprise Technology Solutions

*Excellence in the Business of Government*

**EMPLOYEE INFORMATION - ACCOUNT REQUEST**

USER INFO

NOTE: Please allow a minimum of five (5) working days for the account to be created.

Date:

- New DGS Employee
- Existing DGS Employee Transferring from Another DGS Office/Division
- Existing DGS Employee Transferring Within the Same Office/Division
- Consultant / Student / Retired Annuitant

*** Fields marked in red must be completed before sending this form ***

**Employee Information**

| | | | |
|---|---|---|---|
| Employee Name: | 1 | Title: | 2 |
| Division: | | Start Date: | 3 |
| Branch/Office: | | Phone Number: 123-456-7890 | 4 |
| Section: | | Fax Number: 123-456-7890 | 5 |
| Unit: | | Mobile Number: | 6 |

Name Employee wishes to be known by, if other than full name: 7

Please ensure the employee's name is spelled correctly and that you have indicated any nickname the employee wants to use. The last name MUST match ABMS.

**Business Information**

| | | | |
|---|---|---|---|
| Street: | 8 | Supervisor's Name: | 10 |
| City: | | Supervisor's Phone Number: | |
| State: | Zip Code: | Employee's regular work days: | 11 |
| Employee's Cubicle #: | 9 | Employee's regular work hours: | |

Please click on the "Resource Needs" button to complete the second page.

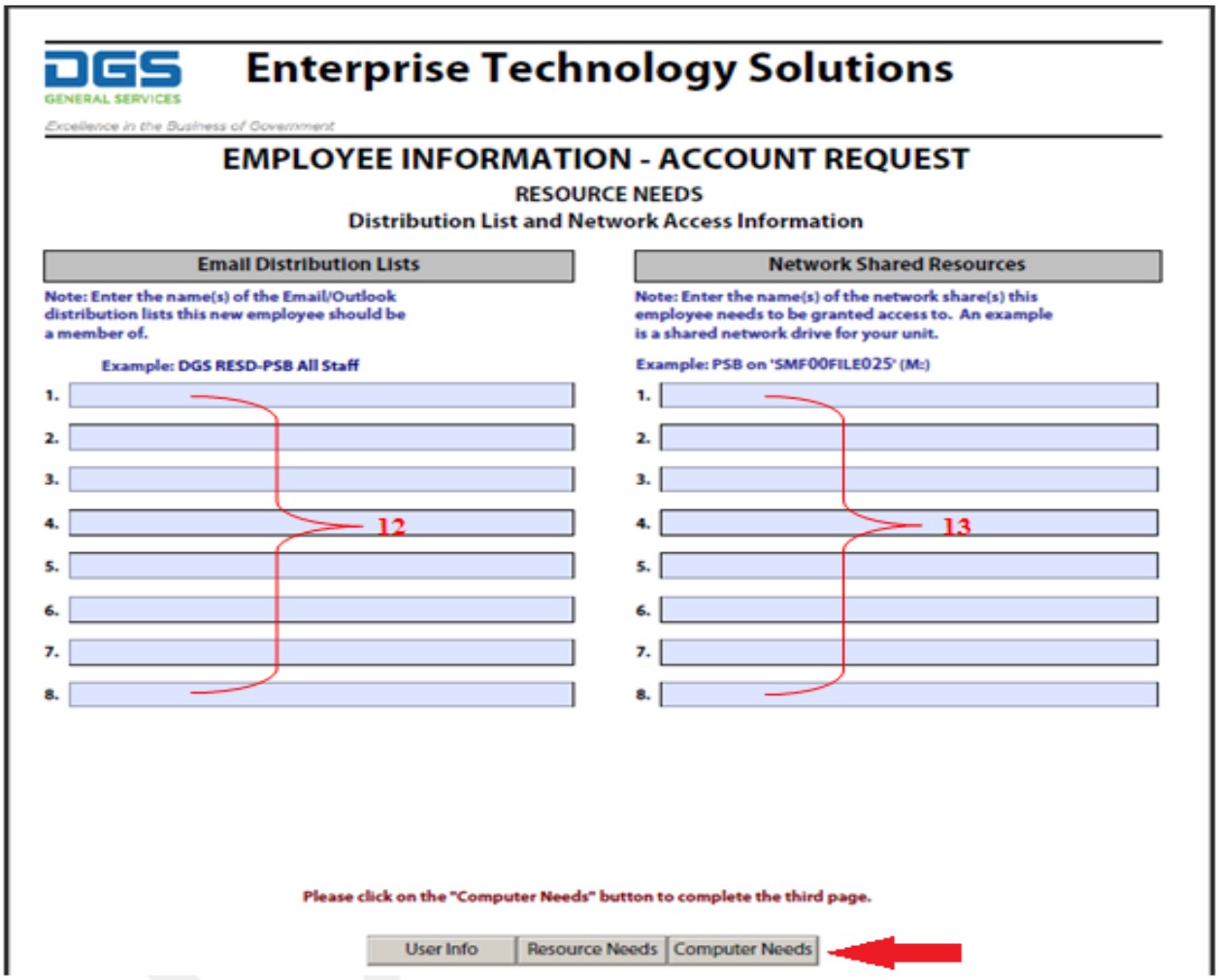
User Info | Resource Needs | Computer Needs

1. Employees Name, Division, Branch/Office, Section, Unit
2. Employee's classification or title
3. Actual date employee will report to work.
4. Phone number to reach employee directly
5. If employee will receive work faxes, indicate the fax number to be used
6. If the employee has a mobile phone for work purposes, supply the number
7. If the employee prefers to be known by a nickname (e.g., Bill instead of William; Mike instead of Michael; Libby instead of Elizabeth; Sue instead of Susan, etc.), put that name here. This is how the account and e-mail address will be created.
8. Work Address
9. If the employee's work space has a number, indicate it here
10. Employee's Supervisor's name and phone number
11. Employee's work days and hours. This information is needed so that the ETS techs will know when they will be able to reach the employee, if necessary to complete work requests.

**Be sure to click on the "Resource Needs" button to advance to the second page.**

# New Employee Setup *Continue*

## Sample/Instruction of Employee Information – Account Request



DGS GENERAL SERVICES

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EMPLOYEE INFORMATION - ACCOUNT REQUEST

RESOURCE NEEDS

Distribution List and Network Access Information

| Email Distribution Lists | Network Shared Resources |
|---|---|
| Note: Enter the name(s) of the Email/Outlook distribution lists this new employee should be a member of. | Note: Enter the name(s) of the network share(s) this employee needs to be granted access to. An example is a shared network drive for your unit. |
| Example: DGS RESD-PSB All Staff | Example: PSB on 'SMF00FILE025' (M:) |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. 12 | 4. 13 |
| 5. | 5. |
| 6. | 6. |
| 7. | 7. |
| 8. | 8. |

Please click on the "Computer Needs" button to complete the third page.

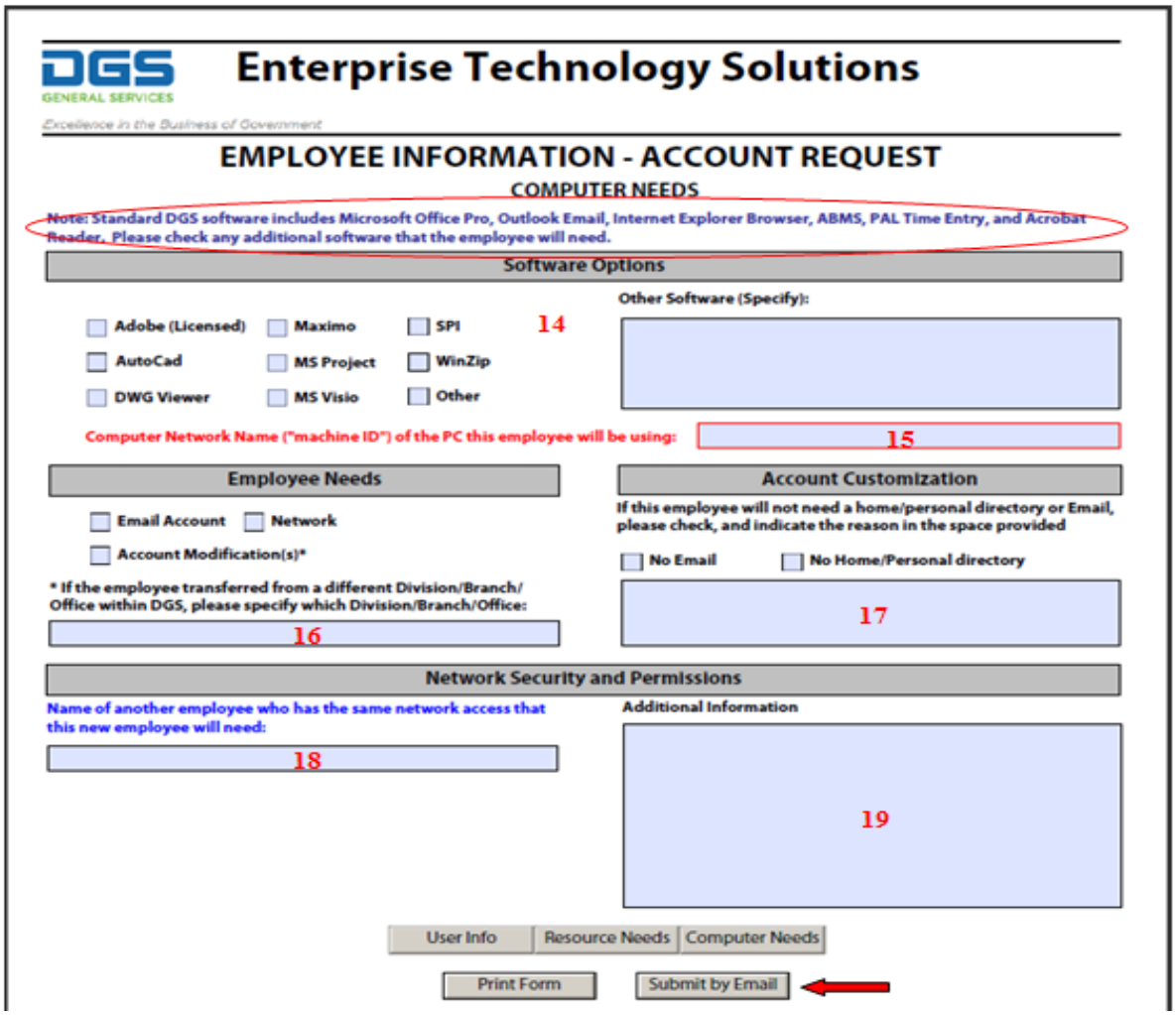
User Info | Resource Needs | Computer Needs

12. Enter the name(s) of each e-mail distribution list this employee should be a member of.
13. Enter the name(s) of each network resource this employee should have access to. For example, a group shared drive that everyone on your team has access to.

**Be sure to click on the "Computer Needs" button to advance to the third page.**

# New Employee Setup *Continue*

### Sample/Instruction of Employee Information – Account Request



DGS GENERAL SERVICES

Enterprise Technology Solutions

*Excellence in the Business of Government*

EMPLOYEE INFORMATION - ACCOUNT REQUEST

COMPUTER NEEDS

Note: Standard DGS software includes Microsoft Office Pro, Outlook Email, Internet Explorer Browser, ABMS, PAL Time Entry, and Acrobat Reader. Please check any additional software that the employee will need.

Software Options

Adobe (Licensed) | Maximo | SPI | 14
AutoCad | MS Project | WinZip
DWG Viewer | MS Visio | Other

Other Software (Specify):

Computer Network Name ("machine ID") of the PC this employee will be using: 15

Employee Needs

Email Account | Network
Account Modification(s)*

* If the employee transferred from a different Division/Branch/ Office within DGS, please specify which Division/Branch/Office: 16

Account Customization

If this employee will not need a home/personal directory or Email, please check, and indicate the reason in the space provided

No Email | No Home/Personal directory

17

Network Security and Permissions

Name of another employee who has the same network access that this new employee will need: 18

Additional Information

19

User Info | Resource Needs | Computer Needs

Print Form | Submit by Email

14. All DGS computers will have the circled software installed. Microsoft Office Pro includes Outlook, Word, Excel, and PowerPoint. Adobe Acrobat Reader allows users to open and read PDF documents. If the employee will need additional software to complete their job duties, you would indicate that here. For example, Adobe (Full) is the licensed, full version that allows the user to create PDF files. If your employee will not be creating this type of document, the Reader is sufficient.
15. Please provide the machine ID of the computer the employee will be using so that we can access it to set up the user's profile, and/or install any additional software.
16. DGS has several instances of more than one employee with the same name. If you are getting a new employee to your unit who already works for DGS (including CBSC, FI$CAL, and CCDA), please indicate that information here, so we can modify the user's existing account rather than create a new account.
17. It would be rare that an employee would not have an e-mail account or a home/personal folder for saving their documents. If your employee does not need e-mail or a home/personal directory, please state why.
18. All employee accounts are assigned specific network access, which governs what area(s) of the network they can access, such as common/shared drives, etc. If you have an existing employee who accesses the same "stuff" that your new employee will need, please give us the existing employee's name so that we can match those security permissions.
19. Any additional comments or information could be typed here.

Click on the **"Submit by Email" button.** This will generate an e-mail message with the form attached. Do not change the "To" line of the message. You may add any Cc addresses, if you wish.

# Date of Appointment Documents

The following table identifies the documents required and is part of the Appointment Package and must be returned with the Appointment Document Checklist to the PS:

YES: Required NO: Not Required Asterisk (*): See Comments

| Appointment Document/ Form Number | New to State Service | Reinstatement | Transfer from Other State Agency | Transfer Within DGS | Comments |
|---|---|---|---|---|---|
| ABMS – Key Employee In Quick Employee Entry | YES* | YES* | YES* | YES* | For directions on entering the employee in QEE and PAL, refer to the ABMS User Guide for Attendance Clerks |
| Application (STD.678) | YES* | YES* | YES* | YES* | Required for all appointments |
| Employee Action Request (STD 686) | YES | YES | OPTIONAL | NO | |
| Oath of Allegiance (STD 689) | YES | YES | NO | NO | Required for all new hires and rehires with a permanent break in service |
| Oath of Office (exempt positions only) (STD 688) | YES* | YES* | YES* | YES* | Employee will not be paid for any day prior to signing oath |
| State Employee Disability Questionnaire | YES | YES | NO | NO | https://exams.spb.ca.gov/disability/DisabilityForm.cfm?dept=IJ00 |
| Race/Ethnicity Questionnaire (CalHR.1070) | YES | NO | NO | NO | |
| CalPERs Member Reciprocal Self-Certification Form PERS-CASD - 801 | YES* | YES* | NO* | NO* | Refer to PL# 13-013 |
| Designation of Persons to Receive Warrants (STD.243) | YES | YES | OPTIONAL* | OPTIONAL* | *If employee's information has changed |

# Date of Appointment Documents *Continue*

YES: Required NO: Not Required Asterisk (*): See Comments

| Appointment Document/ Form Number | New to State Service | Reinstatement | Transfer from Other State Agency | Transfer Within DGS | Comments |
|---|---|---|---|---|---|
| Emergency/Physician Notification (GS-20) | YES | YES | YES | OPTIONAL* | *If employee's information has changed |
| Incompatible Activities Statement | YES | YES | YES | NO | |
| Military Service Information (STD.912) | YES | YES | NO | NO | |
| Asbestos Notification (STD.250) | YES* | YES* | YES* | YES* | *Required only for employees working in building containing asbestos. |
| Anti-Discrimination | YES | YES | YES | NO | DGS' employees only |
| DGS Sexual Harassment Memo | YES | YES | YES | NO | DGS' employees only |
| Union Info Package | YES | YES | YES* | YES* | Classifications in BUs: 1,2,3,4,11,12,14,15,20; *If employee CBID changes. |
| Health Insurance Marketplace Coverage Options and Health Coverage Notice (One time notice to all new hires) | YES | YES | NO | NO | ACs/PLs must complete the section and prove the notice to newly hired employees. **Required for ALL new employees within 14 days of hire. |
| Summary of Benefits and Coverage Notice (one time notice to newly eligible employees) | YES | YES | NO | NO | **Must be provided to all employees newly eligible for health benefits no later than the first day the employee is eligible to enroll in health coverage. |
| ACA Notification Checklist (CalHR Form 782) | YES | YES | NO | NO | **Must provide this Notice along with the health enrollment forms (HBD-12 and HBD-12A) to OHR after completion. |
| Dependent Eligibility Verification Checklist | YES | YES | NO* | NO | *When an employee transfers departments, proper retention of the documents enables the receiving department's OHR staff to see all required documents was submitted/reviewed prior to enrollment. |
| HBD 12 and HBD 12A | YES | YES | NO | NO | Refer to "Employee Benefits" of the AC Manual |

****Affordable Care Act (ACA)** - Failure to comply with the Employer Shared Responsibility provisions could result in significant penalties to the State!

**For benefits refer to "Employee Benefits" in the AC Manual.**

# ABMS – Quick Employee Entry

The Activity Based Management System (ABMS) Quick Employee Entry (QEE) is designed to provide new and transferring employees with timely access to PAL by allowing DGS Attendance Clerks to:

- Create new employee records in ABMS database, and
- Transfer employees from one DGS office to another

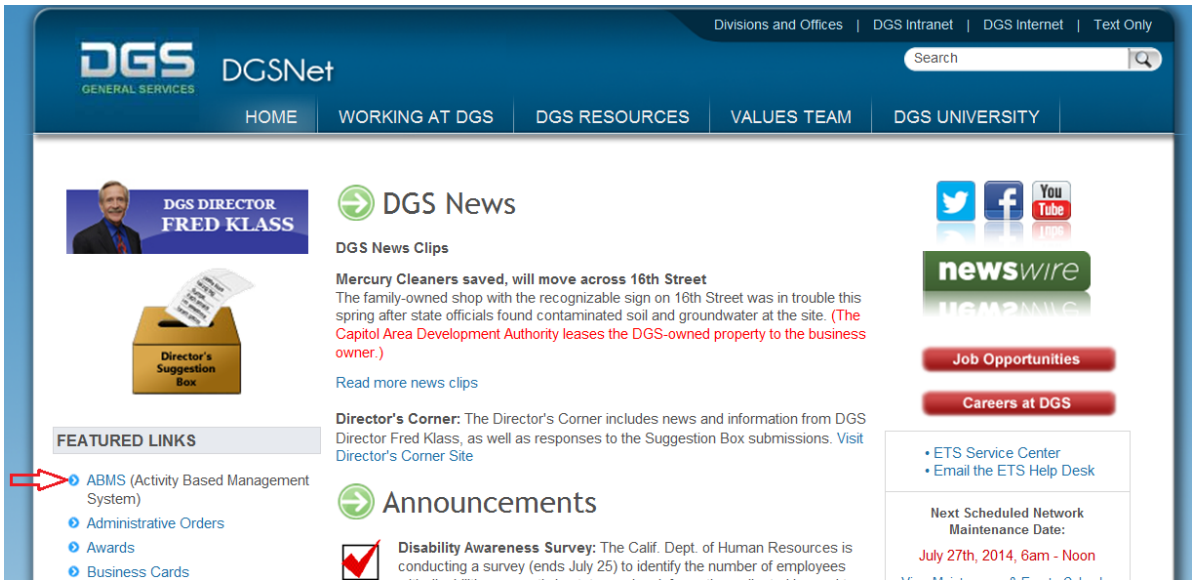
Before submitting the completed Date of Appointment Package to PTU, enter the employee into ABMS QEE.

Upon processing each record, an alert may be launched to notify various staff of the new employee's information.

DO NOT use QEE to create records for Non-DGS (contracted) employees. Contact the ABMS HR Team for assistance.

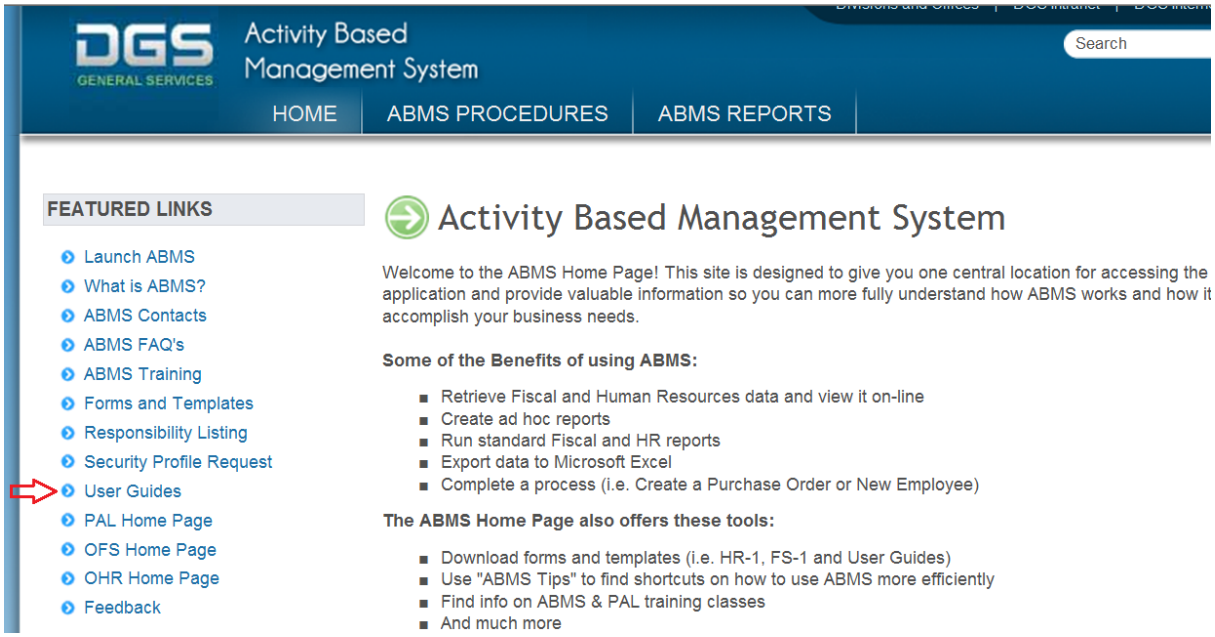
For directions on entering the employee in QEE and PAL, refer to your ABMS User Guide for Attendance Clerk. http://documents.dgs.ca.gov/ABMS/User%20Guides/AC.pdf

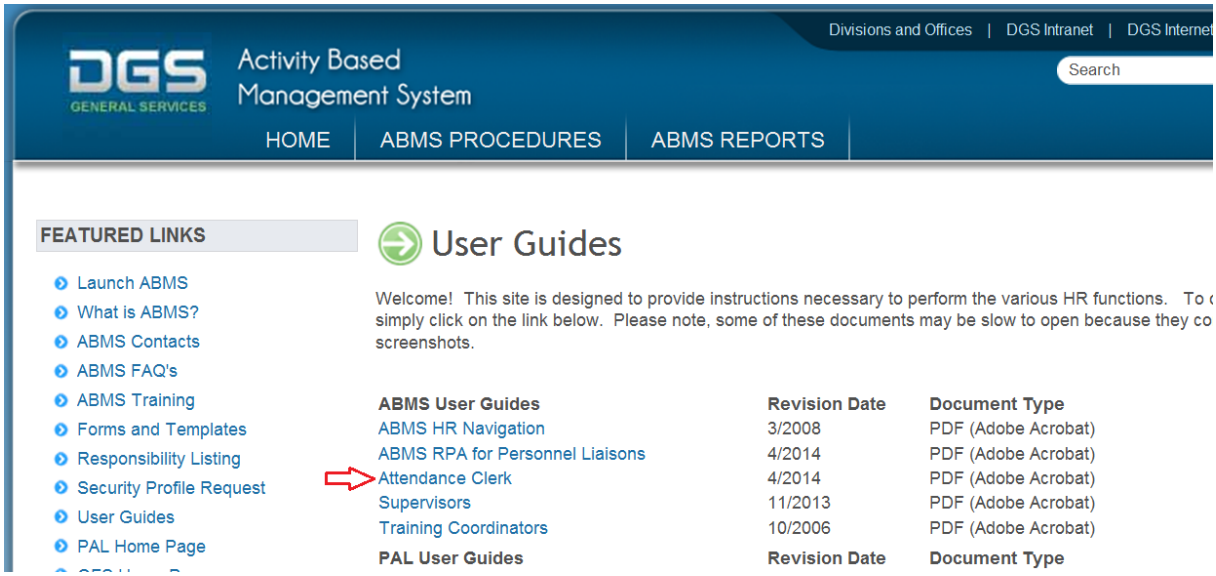
### Access ABMS User Guide



# ABMS – Quick Employee Entry

## **Access ABMS User Guide** Continue



# Application – STD 678

The Examination and/or Employment Application (STD.678) is required for new appointments and transfers to DGS. (Employees who are promotions in place do not need to submit an application.)

The Examination and/or Employment Application is part of the Appointment Package and must be returned with the Appointment Document Checklist.

**Sample of STD 678**

**Form is available at:** www.osp.dgs.ca.gov.

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

**EXAMINATION / EMPLOYMENT APPLICATION**

STD. 678 (REV. 10/2013) Page 1

***Applications will be processed ONLY for classifications where an examination is in progress and the published final filing date has not passed, or for vacant positions where a department requests an application.***

**PRINT OR TYPE–PLEASE SEE INSTRUCTIONS ON BACK PAGE**

SAMPLE

APPLICANT IDENTIFICATION NUMBER (EASY ID)

FIRST 3 LETTERS OF LAST NAME AT BIRTH | MONTH OF BIRTH | DAY OF BIRTH | LAST 4 DIGITS OF SOCIAL SECURITY NUMBER

EASY ID

APPLICANT'S NAME (Last) (First) (M.I.)

SOCIAL SECURITY NUMBER

MAILING ADDRESS (Number) (Street) (Apt. No.)

WORK TELEPHONE NUMBER

(City) (County) (State) (Zip Code)

HOME/PERSONAL TELEPHONE NUMBER

EXAMINATION(S) OR JOB TITLE(S) FOR WHICH YOU ARE APPLYING

PERSONNEL USE ONLY

ANSWER THE FOLLOWING QUESTIONS:

1. Enter the county in which you would like to take the examination if different from the county of your residence: _____
2. Do you need reasonable accommodation to take an interview or written test? _____ ☐ Yes ☐ No
3. Do your religious beliefs prevent you from taking an examination on Saturday? _____ ☐ Yes ☐ No
4. Are you now employed by the State of California? (If "YES", fill in the information below.) _____ ☐ Yes ☐ No
   Department: _____ Subdivision _____
5. Have you ever been fired, dismissed, terminated, or had an employment contract terminated from any position for performance or for disciplinary reasons? (Applicants who have been rejected during a probationary period, or whose dismissals or terminations have been overturned, withdrawn [unilaterally or as part of a settlement agreement] or revoked need not answer "Yes".) Refer to the instructions for further information. If "Yes" to Question #5, give details in the Explanations section. ☐ Yes ☐ No
6. In addition to English, list any other languages you:
   a. possess verbal fluency in _____
   b. possess written fluency in _____
7. I certify I can type at a speed of _____ words per minute. (For typing applicants only.)

(ANSWER QUESTIONS 8 AND 9 ONLY IF THE EXAMINATION INDICATES THEY ARE REQUIRED.)

8. Do you meet the minimum and/or maximum age requirements? _____ ☐ Yes ☐ No
9. Do you possess a valid California Driver License? (If "YES", fill in the information below.) _____ ☐ Yes ☐ No

License # _____ Class: _____ Restrictions: _____

EXPLANATIONS

CERTIFICATION – IMPORTANT – PLEASE READ BEFORE SIGNING – If not signed, this application may be rejected.

*I certify under penalty of perjury that the information I have entered on this application is true and complete to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in my disqualification from the examination process or dismissal from employment with the State of California. I authorize the employers and educational institutions identified on this application to release any information they may have concerning my employment or education to the State of California.*

APPLICANT'S SIGNATURE DATE SIGNED

*APPLICANTS—DO NOT USE THE SPACE BELOW—FOR PERSONNEL USE ONLY*

| Classes | 01 | 02 | 03 | 04 | 05 | 06 | | | |
|---|---|---|---|---|---|---|---|---|---|
| WC for Series/Levels | | | | | | | | | |
| RC/Flag for Series/Levels | | | | | | | | | |

Flags ___ ___ ___ ___ ___ ___ ___

WC ___

CODES

FOR PERSONNEL USE ONLY

STATUS ☐ Accepted ☐ REJECTED WC

EXPERIENCE | LICENSE REQUIREMENT

EDUCATION | OTHER

STAFF | DATE PROCESSED

# Employee Action Request (EAR) STD 686

The Employee Action Request (STD 686) (EAR) is used by the employee to report information necessary for employment such as name, address and tax allowances. The form is utilized by new, reinstated and current employees.

This section offers EAR guidelines when used in the appointment process.

The EAR is subject to annual revisions due to changes in the tax laws, etc. The back of the EAR has general information for the employee's knowledge including taxes, Earned Income Credit and address change.

**Attendance Clerk responsibility**

Review the EAR for clarity and that the employee has completed the required sections. For new hires, the EAR must be returned to the appropriate Personnel Specialist (PS) with the Appointment Document Checklist. After the PS has processed the EAR, the employee's copy will be returned to the AC for distribution to the employee. The original is filed in the employee's OPF.

| Required | Not Required |
|---|---|
| An EAR is required for:<br>▪ New hire to state service<br>▪ Reinstatement from permanent separation with a break in service<br>▪ Emergency appointment<br>▪ Current employee reporting a change | Unless the employee has changes to report, an EAR is not required:<br>▪ Returning from a temporary separation (e.g., IDL, NDI, and Leave of Absence)<br>▪ Transferring between departments<br>▪ Appointed to an additional appointment |

# Employee Action Request (EAR) *Continue*

## Sample of Employee Action Request (STD. 686)

**Form is available at:** www.osp.dgs.ca.gov.

Print Clear

Who is authorized to resolve your pay warrant in case of death? Contact your personnel office to update your designee's name or address. (Form STD. 240). Save also retirement beneficiary information on reverse side of employee copy.

STATE OF CALIFORNIA – STATE CONTROLLER'S OFFICE
STD. 686 (REV. 7/2007d) (FRONT)

**EMPLOYEE ACTION REQUEST**

**PERSONNEL OFFICE USE**

A: 01 AGENCY | 02 UNIT | 03 KEYED BY | 04 DATE KEYED

CHECK ONE OR MORE BOX(ES) AND COMPLETE LISTED SECTIONS. RETURN COMPLETED FORM TO YOUR PERSONNEL OFFICE. USE BALLPOINT PEN AND PRINT CLEARLY. NO CARBON REQUIRED.

B: 01 ☐ New Employee (SECTIONS C, E, F, G, H, I) | 03 ☐ Withholding Allowance Change (SECTIONS C, E, I) | 04 ☐ *Address Change } SECTIONS C, F, I | 05 ☐ Name Change (Attach Subdivision) (SECTIONS C, D, I) | 07 ☐ Birthdate Correction (SECTIONS C, H, I)

NOTE: Social Security Number and Last Name, First Name, and Middle Initial must be entered exactly as shown on Social Security card.

C: 01 SOCIAL SECURITY NUMBER | 02 EMPLOYEE LAST NAME | 03 FIRST NAME AND MIDDLE INITIAL

D: NAME CHANGE — FORMER NAME (Last, First and Middle)

**WITHHOLDING ALLOWANCE CHANGE OR NEW EMPLOYEE**

***IMPORTANT*** Before completing Section E, you must read IRS Form W-4 and the applicable state tax form. (For California use Form DE-4.)

E

I. FEDERAL AND STATE ALLOWANCE – For Tax Purposes Only: If no tax should be withheld, complete Part IV or V only.

01 ☐ NONRESIDENT ALIEN (See back of third page)

02 MARITAL STATUS FOR TAX PURPOSES ONLY (Check One)

☐ SINGLE ☐ MARRIED

03 ☐ TOTAL - Number of allowances you are claiming

NOTE: Employers may be required to notify IRS of the number of allowances claimed.

II. SPECIAL TREATMENT OF STATE ALLOWANCES – Complete boxes 03 thru 05 if you wish your State withholding to be different than what you claim for a withholding (IF BOXES ARE NOT COMPLETED, CURRENT SPECIAL TREATMENT (IF ANY) WILL BE CANCELLED.)

04 MARITAL STATUS FOR TAX PURPOSES ONLY (Check One)

☐ SINGLE ☐ MARRIED ☐ HEAD OF HOUSEHOLD

05 ☐ REGULAR ALLOWANCE(S) Total you are claiming

06 ☐ ADDITIONAL ALLOWANCE(S) Total you are claiming

NOTE: Employers may be required to notify EDD if more than 10 allowances are claimed.

III. ADDITIONAL DEDUCTIONS – Complete box 06 and/or 07 if you wish additional Federal and/or State tax withheld from your wages. Part I (and Part III, if your State allowance claim differs from your Federal) must be completed. The first deduction will be made from your earnings for the pay period in which this form is processed. IF BOXES ARE NOT COMPLETED, CURRENT DEDUCTIONS (IF ANY) WILL BE CANCELLED.

I hereby authorize the State Controller to deduct monthly from my wages the additional Federal and/or State tax amount specified below. I understand that if boxes are not completed, current deductions, if any, will be cancelled.

06 $ ☐ FEDERAL ADDITIONAL DEDUCTION | 07 $ ☐ STATE ADDITIONAL DEDUCTION

IV. EXEMPTION FROM WITHHOLDING – Check box 08 if you are eligible to claim exemption from withholding. No Federal or State income tax will be withheld from your wages. DO NOT COMPLETE PARTS I, III OR III. (See General Information on back of third page.)

08 ☐ *I claim exemption from withholding because of no tax liability:* Last year I did not owe any income tax and had a right to a full refund of ALL income tax withheld, AND this year I do not expect to owe any income tax and expect to have a right to a full refund of ALL income tax withheld.

NOTE: This exemption will automatically expire on February 15 of next year unless you file a new certification by January 31 of next year. Employers may be required to notify IRS if you earn more than $200 per week.

V. NONTAXABLE WAGES – Check box 09 if wages you will receive are not subject to income tax withholding.

09 ☐ I claim that the wages I will be receiving from the State are either a 1) MINISTER OF A CHURCH in the exercise of his/her ministry, 2) NONIMMIGRANT ALIEN wages, or 3) DECEASED EMPLOYEE WAGES. Indicate reason (See General Information on back of third page.).

SAMPLE

**ADDRESS CHANGE OR NEW EMPLOYEE** *Save Back of Third Page

F: 01 EMPLOYEE ADDRESS (Street, Apt. No., P.O. Box) | 02 CITY | 03 STATE | 03 ZIP CODE

04 EMPLOYMENT LIST

☐ Check this box and enter your phone number(s) if your address is changing and your name appears on any departmental employment list. (See back of third page.)

WORK PHONE | HOME PHONE

**NEW EMPLOYEE** THIS INFORMATION MAY BE USED TO LOCATE PRIOR PUBLIC EMPLOYMENT SERVICE FOR STATE SERVICE CREDITS AND/OR RETIREMENT SYSTEM BENEFITS.

G: 01 LAST EMPLOYED BY CALIFORNIA STATE AGENCY OR CAMPUS OF: | 01 LAST NAME (If different) | 03 SEPARATED MO YR | 04 LAST EMPLOYED BY CALIFORNIA PUBLIC AGENCY OF: (City, County, Public School or Utility, etc.) | 05 LAST NAME (If different) | 06 SEPARATED MO YR

**NEW EMPLOYEE OR BIRTHDATE CORRECTION**

H: BIRTHDATE MO DAY YR

**EMPLOYEE SIGNATURE**

I: *I certify that the above information is true and correct and that I have read the IRS Form W-4 and the applicable state form. Under the penalties of perjury, I certify that the number of withholding exemptions and allowances claimed on this certificate does not exceed the number to which I am entitled. If claiming exemption from withholding, I certify that I incurred no tax liability in last year and that I anticipate that I will incur no liability this year. I authorize my employer via the State Controller's Office to refund any overcollection of current/prior year Social Security and Medicare taxes; I certify that I shall not claim a tax refund or credit for these overcollections.*

EMPLOYEE SIGNATURE | DATE

White – Personnel/Payroll Services Div. | Yellow – Personnel | Pink – Employee

**PERSONNEL OFFICE USE**

J: REVIEWER'S SIGNATURE | DATE | PHONE NO.

# Employee Action Request (EAR) *Continue*

## Sample of Employee Action Request (STD. 686)

## "Information for Employees"

STATE OF CALIFORNIA – STATE CONTROLLER'S OFFICE

**EMPLOYEE ACTION REQUEST**

STD. 686 (REV. 7/2007c) (BACK, EMPLOYEE COPY)

### INFORMATION FOR EMPLOYEES COVERED BY THE PUBLIC EMPLOYEES' RETIREMENT SYSTEM (PERS)

You are entering into membership in the Public Employees' Retirement System (PERS) which provides you and your fellow State employees with retirement and other benefits. Member contributions, those contributions made by the State of California, and the interest earned on investments provide for service retirement, disability retirement, and death benefits. An information booklet is available from your personnel office. The booklet describes your particular benefit coverage in detail.

#### BENEFICIARIES FOR DEATH BENEFITS

1. ***STATUTORY BENEFICIARIES*** – If you should die while in employment covered by PERS and you do not name other beneficiaries, death benefits will be paid to your survivors in the following order:
   a. Your spouse (husband or wife) or domestic partner.
   b. If you have no spouse or domestic partner, your children (share and share alike).
   c. If you have no spouse, domestic partner, or children, your parents (share and share alike).
   d. If you have none of the above, the benefits will be paid to your estate. If your estate will not be probated, payment will be made to next of kin as provided by law.
2. ***NAMING DIFFERENT BENEFICIARIES*** – If you wish, you may at any time name different beneficiaries or change the order of those listed as statutory. To do so, you must file with PERS, a Beneficiary Designation (State Form STD. 241), obtainable from your personnel office. **DO NOT FILE FORM STD. 241 IF THE STATUTORY BENEFICIARIES LISTED IN ITEM NO. 1 ARE SATISFACTORY.**

Each time you have a change in marital status, domestic partnership status, or you acquire a child by birth or adoption, the Public Employees' Retirement Law will automatically revoke any previously named beneficiaries and establish statutory beneficiaries as listed in Item No. 1. If the statutory beneficiaries are not satisfactory, you must file a form STD. 241 to reflect your desired change.

#### RESTORATION OR PURCHASE OF RETIREMENT SERVICE CREDIT

If you were a former member of the Public Employees' Retirement System (PERS) and withdrew your contributions, you have the right to redeposit those funds as a member of the first-tier retirement plan and restore your previous service; or your previous state service may be restored at no cost if you are a member of the second-tier plan and you have elected to have all past service credited to your account. You may also have the right to receive retirement service credit for state employment in which you were not a PERS member. Additional retirement service credit will in most cases increase your potential retirement benefits. Information on restoration or purchase of retirement service credit may be obtained by writing to the Public Employees' Retirement System, Member Services Division – 832, P.O. Box 942704, Sacramento, CA 94229-2704.

SAMPLE

#### GENERAL INFORMATION

##### TAXES

**IF YOU ARE A NONRESIDENT ALIEN PER INTERNAL REVENUE SERVICE (IRS) NOTICE 2005-76** check the Nonresident Alien box. If you have questions about whether you should mark this box, you should contact your human resources office.

**IF YOU ARE EXEMPT FROM EITHER FEDERAL OR STATE WITHHOLDING,** but not exempt from both, contact your personnel office for special instructions.

**IF YOU WILL RECEIVE NONTAXABLE WAGES,** please indicate the reason on your withholding claim in the space provided. The reason must be one of the following:

a. "Minister of the church in the exercise of his / her ministry" – employed by the State of California as a Chaplain.

b. "Nonimmigrant Alien per Tax Treaty" (indicate claim: "Exempt per Article _____ of treaty between United States and (Country).") Tax Treaty must cite exemption from both Federal and State personal income tax to qualify for this exemption.

c. "Deceased Employee Wages" – agency administrative action.

**IF YOU HAVE ANY QUESTIONS REGARDING YOUR ELIGIBILITY UNDER ANY OF THE ABOVE REASONS,** you should contact your local Internal Revenue Service Office or the Employment Tax District Office of the Employment Development Department.

**EMPLOYEES WITH TWO OR MORE CONCURRENT JOBS WITH THE STATE OF CALIFORNIA.** The allowances you claim on this form will be used for tax withholding purposes for all wages paid under the Uniform State Payroll System. The Uniform State Payroll System includes all California State Agencies (except as noted below) and the California State Universities. It does not include the California Agricultural Associations, the University of California or Legislative employees.

**IF YOUR NORMAL LOCATION OF EMPLOYMENT IS NOT IN CALIFORNIA** and you are a California State employee, you may be eligible to have income tax for another state withheld from your wages under the reciprocity provisions required by G.C. 1170.5. Contact your personnel office for additional information.

##### EARNED INCOME CREDIT (EIC)

You may be entitled to an income tax refund or credit from the Internal Revenue Service (IRS) if you meet certain eligibility requirements relating to your annual income and family size. You have the option of receiving advance payments of the earned income credit each month or claiming the credit on Form 1040 or 1040A, your annual tax return, and receiving the credit when you file. To find out more information about the credit, contact your personnel/payroll office or IRS at 1-800-829-1040. To request advance EIC payments, you must complete a Form W-5, Earned Income Advance Payment Certificate. The W-5 is available at your local IRS office or can be ordered by calling 1-800-829-3676.

##### ADDRESS CHANGE

**IF YOU HAVE A U.S. SAVINGS BOND DEDUCTION** and the address of the registered owner is changing, you must complete a new United States Savings Bonds Purchase/Payroll Deduction Authorization, STD. 242.

**IF YOU HAVE OTHER DEDUCTIONS,** you must change your address with the deduction company. This form does not affect an address change with deduction companies.

**IF YOUR NAME APPEARS ON ANY DEPARTMENTAL EMPLOYMENT LIST** (Open, Promotional, Reemployment, etc.), and your address is changing, check Box 04 and enter your phone number(s) in Section F. Your department will update the appropriate list(s) with this information.

#### PRIVACY NOTIFICATION

The Information Practices Act of 1977 (California Civil Code Section 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (e)(3)) require this notice to be provided when collecting personal information from individuals.

The information you are asked to provide on this form is requested by the Office of the State Controller, Personnel/Payroll Services Division. The information will be used by the State Controller's Office for personnel, payroll, retirement and health benefits processing.

Furnishing the information requested on this form is mandatory except for Prior Public Employment (Section G). Furnishing prior public employment information is voluntary. Noncompliance in providing your social security number and name will result in refusal of employment. Failure to furnish other requested information may result in inaccurate determination of credit for State service, payroll calculations, retirement and/or health benefits.

Legal references authorizing the maintenance of this information by the State Controller's Office include: Federal Internal Revenue Code (26 USC Sections 3402(a), 6011, 6051, and 6109) and the regulations thereto; Federal Public Health and Welfare Code (42 USC Section 408); and California Government Code Sections 12470 through 12479 and 16391 through 16395; California Unemployment Insurance Code Section 13020; delegated authority from the State Personnel Board; and delegated authority from the Trustees of the California State University.

Certain items of information furnished on this form may be transferred to the following governmental or private agencies where authorized by law; State Personnel Board, Department of Personnel Administration, Trustees of the California State University, Employment Development Department, Department of Social Services, Department of Finance, Public Employees' Retirement System, employing State agencies and campuses, Social Security Administration, Federal Internal Revenue Service, California State Franchise Tax Board, other state income tax bureaus and other governmental entities when required by state or federal law, organizations for which deductions are authorized by law, and collective bargaining organizations.

Employees have the right to review their own personal information maintained by the State Controller's Office unless access is exempted by law.

Contact: Personnel/Payroll Services Division, State Controller's Office, P.O. Box 942850, Sacramento, CA 94250-5878.

# Employee Action Request (EAR) *Continue*

**Completing the EAR**

**SECTION A** PTU must complete Section A. (Personnel Office Use)

| Section | Box Number | Action |
|---|---|---|
| A | 01 | PS will enter the 3 digit agency number. |
| | 02 | PS will enter the 3 digit reporting unit number. |
| | 03 | PS will enter their initials. |
| | 04 | PS will enter the date in which the EAR is keyed. |

If the Attendance Clerk knows the 3 digit agency and unit number, you may enter the numbers for the PS.

**SECTION B** All employees (New or Current) submitting an EAR must check the applicable boxes in Section B and complete the appropriate sections.

**New Employees**

| Section | Box Number | Action |
|---|---|---|
| B | 01 | For the new employee only<br>(complete required sections C, E, F, G, H & I) |

**Or**

**Current Employees**

| Section | Box Number | Action |
|---|---|---|
| B | 03 | To change withholding allowance<br>(complete required sections C, E & I) |
| | 04 | To change address<br>(complete required sections C, F & I) |
| | 05 | To change name<br>(complete required sections C, D & I) |
| | 07 | To change birth date<br>(complete required sections C, H & I) |

# Employee Action Request (EAR) *Continue*

**SECTION C** All employees must complete Section C.

**New, Current and Reinstating Employees**

| Section | Box Number | Action |
|---|---|---|
| C | 01 | Always show social security number.<br><br>**NOTE:** If a new employee does not have a social security number card, enter "SS5" in Box 01. |
| | 02 | • Enter the employee's last name (For a name change, enter new name)<br><br>• Last name must include Jr., Sr., II, III, if appropriate |
| | 03 | Enter the first name and middle initial (For a name change, enter new name) |

*Note: Enter exactly as it appears on the social security card

**SECTON D** Current employees reporting a name change or an employee reinstating with a new name must complete Section D.

**Current OR Reinstating Employee With A New Name**

| Section | Box Number | Action |
|---|---|---|
| D | | • Enter former name (last, first and middle initial)<br><br>• Print small and legibly<br><br>• Complete new Designee Form, STD 243<br><br>Substantiation must be attached to EAR when reporting a name change unless returning from a permanent break in service |

# Employee Action Request (EAR) *Continue*

**Substantiation Required for a Name Change**

Either Form 5028 from the Social Security Administration, a copy of the new social security card, or other confirmation form issued by the Social Security Administration must be attached to the EAR. A marriage certificate is not valid proof that the employee has changed her name through the Social Security Administration.

**SECTON E** All new employees or current employees wishing to change their withholding allowance must complete Section E.

**New, Current and Reinstating Employees**

| Section | Box Number | Action |
|---|---|---|
| E | | If no tax is to be withheld, complete Part IV or V only.<br><br>I. Check one of the marital status boxes as it applies to tax purposes only.<br>II. Complete only if the State taxes will differ from Part I.<br>III. For additional deductions for taxes, enter the specific amount to be deducted in addition to the federal and state allowances in Part I.<br>IV. Check this box if employee is exempt from having taxes deducted from pay warrant. Parts I, II, III and V must be left blank.<br>V. If employee is eligible for Non-Taxable Wages as explained on the back of the EAR, check this box. Parts I, II, III and IV must be left blank. |

**Comment:** If not completed, the State Controller's Office will deduct taxes based on prior information if a reinstatement is within 12 months. If prior separation is over 12 months and Section E is not completed, the deduction will be Single and Zero (S-0).

If Section E is not completed by a new employee, the Controller's Office will deduct as a single person with no exemptions (S-0).

# Employee Action Request (EAR) *Continue*

**SECTION F** All new employees or current employees reporting a change of address must complete Section F.

**New and Current Employee**

| Section | Box Number | Action |
|---|---|---|
| F | 01 | Employee address |
| | 02 | City and state |
| | 03 | Zip code |

Complete Section F as follows if the employee is on a departmental employment list (open, promotional, etc.). The Certification Unit will update the appropriate list(s).

**Employee On DGS Employment List(s)**

| Section | Box Number | Action |
|---|---|---|
| F | 04 | To change address on departmental employment list(s) |

**SECTION G** All new employees or an employee reinstating with a new name must complete Section G.

**New and Reinstating Employees**

| Section | Box Number | Action |
|---|---|---|
| G | 01& 04 | Complete only if new employee has had prior State or public agency service |
| | 01& 05 | Enter last name only if different from the name in Section C |
| | 03 & 06 | Enter month/year of prior separation if applicable |

# Employee Action Request (EAR) *Continue*

**SECTION H** All new employees or employees reporting a birth date correction must complete Section H.

**New, Current and Reinstating Employees**

| Section | Box Number | Action |
|---|---|---|
| H | | Complete birth date using six digits. Zero filled to the left for numerals 01-09. (mm/dd/yy)<br><br>**Note:** A copy of the birth certificate is required when reporting a birth date correction |

**SECTION I** All employees must complete Section I.

**New, Current and Reinstating Employees**

| Section | Box Number | Action |
|---|---|---|
| I | | Employee signs and dates form |

**Social Security Number Correction**

Do not include any other changes on EAR when submitting a social security number correction. A copy of the employee's social security card must be attached to the EAR when submitting a social security number correction.

| Section | Box Number | Action |
|---|---|---|
| B | 01 | • Check Box 01<br>• Line off New Employee<br>• Print "SS# Correction" under New Employee<br><br>**Example**: NEW EMPLOYEE - SS# Change |
| C | 01 | • Enter old social security number on top<br>• Enter new number directly below in the same space<br><br>**Example**: 523-49-6871<br>523-94-6871 |
| | 02 & 03 | Enter the employee's name as it appears on the ALS Report |
| I | | Employee signs and dates the form |

# Oath of Allegiance

**Oath of Allegiance and Declaration of Permission to Work for Persons Employed by the State of California (STD 689)**

The Oath of Allegiance (STD 689) is required for new hires to State civil service and reinstatements with a break in service.
Exempt employees are not required to complete the Oath of Allegiance. See Oath of Office for Exempt Appointments.

**Attendance Clerk Responsibilities**

Review the Oath of Allegiance for accuracy and verify all required sections are completed. The original Oath of Allegiance must be returned to your PS with the Appointment Document Checklist. The original is filed in the employee's OPF.

# Oath of Allegiance *Continue*

**Sample of Oath of Allegiance and Declaration of Permission to Work for Persons Employed by the State of California (STD.689)**

**Form is available at:** www.osp.dgs.ca.gov.

STATE OF CALIFORNIA – STATE PERSONNEL BOARD

**OATH OF ALLEGIANCE AND DECLARATION OF PERMISSION TO WORK FOR PERSONS EMPLOYED BY THE STATE OF CALIFORNIA**

STD. 689 (REV. 5/2002)

*Oath may be administered by a person having general authority by law to administer oaths, or may be administered by the appointing power, or by a person for whom written authorization to witness oaths has been executed by the appointing power. The appointing power maintains a file of such authorizations.*

PART 1 OATH OF ALLEGIANCE
*TO BE COMPLETED BY UNITED STATES CITIZENS ONLY*

**WHO MUST SIGN OATH**—As required in Section 3 of Article XX of the Constitution of the State of California, every State employee except legally employed noncitizens, must sign the following oath or affirmation before he or she enters upon the duties of his or her State employment. Noncitizens are required to possess a Declaration of Permission to Work. If an alien employee becomes a naturalized citizen, an oath must then be obtained and filed.

**WHEN OATH MUST BE SIGNED**—As required in Government Code Section 3102, all public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council must sign an oath or affirmation before entering upon the duties of their employment or volunteer work. In temporary or emergency employments, an oath or affirmation may, at the discretion of the employing agency, be effective for all successive periods of employment which commence within one calendar year from the date of the oath.

SAMPLE

***OATH OF ALLEGIANCE** (Type or print name of employee, then complete Part 3.)*

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

**WHERE OATHS ARE FILED**—As required in Government Code Section 3105, all oaths for public employees and all volunteers in any disaster council or emergency organization accredited by the California Emergency Council shall be filed in the official employee file within 30 days of the date the oath is executed. The oath is considered a public record.

**FAILURE TO SIGN**—As stated in Government Code Section 3107, no compensation or reimbursement for expenses incurred shall be paid to any public employee or any volunteer in any disaster council or emergency organization accredited by the California Emergency Council unless such public employee has taken and subscribed to the oath or affirmation.

**PENALTIES** (Government Code)

"3108. Every person who, while taking and subscribing to the oath or affirmation required by this chapter, states as true any material matter which he knows to be false, is guilty of perjury, and is punishable by imprisonment in the state prison not less than one nor more than 14 years."

PART 2—DECLARATION OF PERMISSION TO WORK
*TO BE COMPLETED BY LEGALLY EMPLOYED NONCITIZENS ONLY*

I am a lawful permanent resident alien of the United States. ☐ YES ☐ NO

If NO, please read the following:

I hereby certify that I have permission to work in this country and have declared any restrictions placed upon me in this regard by the United States government to the appointing power.

PART 3—SIGNATURE AND CERTIFICATION *(No fee may be charged for administering)*
*TO BE COMPLETED BY UNITED STATES CITIZENS AND LEGALLY EMPLOYED NONCITIZENS*

| | |
|---|---|
| EMPLOYEE'S SIGNATURE | |
| STATE DEPARTMENT OR AGENCY / DIVISION/UNIT | |
| Taken and subscribed before me this _____ day of _____ | |
| AUTHORIZED OFFICIAL'S SIGNATURE | |
| AUTHORIZED OFFICIAL'S TITLE | (SEAL) |

# Oath of Allegiance *Continue*

## Completing the Oath of Allegiance

| | |
|---|---|
| **PART 1**<br>**Oath of Allegiance** | Type or print in ink employee's name in the space provided |
| **PART 2**<br>**Declaration of Permission to Work** | Employee shall:<br><br>• Check "YES": if employee is a lawful permanent resident of the United States<br>• Check "NO": leave blank |
| **PART 3**<br>**Signature and Certification** | Completed by Attendance Clerk and employee:<br><br>• Employee's signature*:* employee will sign<br>• State Department or agency*:* Enter DGS or Client Agency name<br>• Division/Unit: enter the DGS office name or Client Agency name<br>• Taken and subscribed*:* enter the date signed<br>• Authorized official's signature: you shall sign<br>• Authorized official's title: your title (i.e. Attendance Clerk) |

# Oath of Office

The Oath of Office (STD 688) must be completed no later than the first date of appointment. Exempt appointees that are required to complete the Oath of Office by law may not be compensated for time worked prior to the date the Oath is certified.

All exempt appointments are required to complete the Oath of Office.

**Attendance Clerk responsibilities**

Forward a copy of Oath of Office to the PS within 30 days of the appointment date. The PS will file in the employee's OPF.

**Sample of the Oath of Office (FRONT)**

**Form is available at:** www.osp.dgs.ca.gov.

## OATH

*for the Office of* _____

_____

*I,* _____ *, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.*

SAMPLE

*Signature* _____

*Term Expires* _____

*Subscribed and sworn to before me,*
*this* _____ *day of* _____
*A. D.* _____

_____

_____

# Oath of Office *Continue*

**Sample of the Oath of Office (REVERSE)**

**OATH OF OFFICE**

***of***

SAMPLE

STD. 688 (REV. 11-99) (REVERSE)

# Oath of Office *Continue*

### Completing the Oath of Office

You may type or use a ballpoint pen to complete the Oath of Office. Do not use a pencil.

| | |
|---|---|
| **For the Office of** | Exact title of the position as specified in Departmental Pay Scales. |
| **I,** | Appointee's name. |
| **Signature** | Appointee signs the Oath. |
| **Term Expires** | Termination date as per entitlement. |
| **Subscribe and sworn, etc. (certification)** | Certified by only one specific employee as listed:<br>▪ Notary Public<br>▪ Judges<br>▪ Justice of the Peace<br>▪ Governor's Appointee<br>▪ Agency Secretary<br>▪ Director |

The date of certification ***must*** be the date of appointment.

# State Employee Disability Questionnaire

Pursuant to the Rehabilitation Act of 1973 and Government Code Section 19233, CalHR requires that departments survey their employees to determine the number of individuals with a disability employed in each department.

In an effort to “Go Green”, effective November 1, 2011, CalHR has eliminated the paper disability survey process. Employees now have 24/7 direct access to this confidential online system from any computer. Employees need only to enter their last name and the last four digits of their social security number.

### Attendance Clerk responsibilities

Attendance Clerks (ACs) must inform the new to State employees and current employees who have a status change that the survey is now available online from any computer. ACs must direct employees to the confidential online system via our department’s survey link at: Disability Survey.

(https://exams.spb.ca.gov/disability/DisabilityForm.cfm?dept=IJ00)

***Important!*** **The disability information requested on the questionnaire may only be collected on a voluntary basis.**

# State Employee Race/Ethnicity Questionnaire (CalHR 1070)

The Race/Ethnicity Questionnaire (CalHR 1070) is required for employees new to State service only. The employee's response to the Race/Ethnicity Questionnaire is voluntary. If the employee chooses not to identify, the department is required to visually identify under the federal law.

The questionnaire allows the employees to self-identify the race/ethnic group with which he/she most closely identifies. The Ethnic/Race is encoded by the department's personnel office and becomes part of the employment history system kept by the State Controller's Office (SCO).

The original Race/Ethnicity Questionnaire must be returned to your PS with the Date of Appointment Document Checklist.

**Completing the Race/Ethnicity Questionnaire (CalHR 1070)**

| |
|---|
| **Type or print in the spaces provided:**<br><br>• Department: DGS or client agency, e.g., EMSA<br>• Employee's name<br>• Employee's last 4 digits of social Security Number<br>• Check the appropriate box for male or female |
| **Employee shall:**<br><br>• Check one of the ethnicity box that best describes race/ethnicity |
| **Employee shall:**<br><br>• Sign name and date |

# State Employee Race/Ethnicity Questionnaire (CalHR 1070) *Continue*

**Sample of CalHR 1070**

**Form is available at:** http://www.calhr.ca.gov/Pages/home.aspx

California Department of Human Resources

**STATE EMPLOYEE RACE/ETHNICITY QUESTIONNAIRE**

(For All New Hires and Rehires)
CalHR 1070 (Rev. 02/13)

**INSTRUCTIONS:**

All new/rehired employees are requested to voluntarily self-identify their race/ethnicity and gender in order to monitor and evaluate the provision of equal employment opportunity and non-discriminatory employment practices within the State civil service. Complete the form promptly and return it to your department's Personnel Office with your other hiring documents.
**Note:** If you choose not to identify, the department is required to visually identify under federal law.

| Department | Employee's Name | Last 4 digits of Social Security Number | Person ID Number (If applicable) | Gender ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

Please check one of the boxes that best describes your race/ethnicity heritage.

| Asian Groups | Hispanic Groups | Pacific Islander Groups | Other Groups |
|---|---|---|---|
| ☐ Asian Indian (M) | ☐ Cuban (C) | ☐ Guamanian or Chamorro (R) | ☐ Aleut (O) |
| ☐ Cambodian (U) | ☐ Mexican/ Mexican-American (A) | ☐ Hawaiian (P) | ☐ American Indian/ Native American (H) |
| ☐ Chinese (J) | ☐ Puerto Rican (B) | ☐ Samoan (Q) | ☐ Black/African American (F) |
| ☐ Filipino (G) | ☐ Other Hispanic/Latino Group (D) | ☐ Other Pacific Islander Group (T) | ☐ Eskimo (N) |
| ☐ Japanese (I) | | | ☐ White (E) |
| ☐ Korean (K) | | | |
| ☐ Laotian (V) | | | |
| ☐ Vietnamese (L) | | | ☐ Choose not to identify |
| ☐ Other Asian Group (S) | | | |

SAMPLE

Employee Signature _____ Date _____

PRIVACY STATEMENT

AUTHORITIES

Collection of race/ethnicity and gender information on State employees is authorized pursuant to Government Code sections 19792 (h), 19799 and 8510.5, which requires the California Department of Human Resources (CalHR) to maintain a statistical information system designed to yield the data and the analysis necessary for the evaluation of equal employment opportunity programs in the State civil service, and use separate collection categories.

The data is encoded by the department's Personnel Office and becomes part of the employment history system kept by the State Controller's Office. It is shared only with CalHR and the employing department and is used only for statistical purposes in evaluating the extent to which the State is complying with State and federal equal employment opportunity and non-discrimination requirements.

SOCIAL SECURITY NUMBER

Providing the last four digits of your Social Security Number is voluntary in accordance with the Privacy Act of 1974 (PS 93-579). If you do not provide this, your information cannot be accurately counted and included in your department's workforce statistics. The information contained on this form is confidential.

DEPARTMENT

If an employee chooses not to identify, visual identification is required by federal law and regulation to meet EEO-4 reporting requirements (Public Law 88-352, Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972 and Title 29, Chapter XIV, Code of Federal Regulations Subpart I-State and Local Governments Recordkeeping, Section 1602.30). Departments may confidentially destroy this form after it has been keyed.

# CalPERS Members Reciprocal Self-Certification Form (PERS-CASD-801)

Reciprocity is an agreement among public retirement systems to allow members to separate from one public employer and into employment with another public employer within a specific time limit without losing some valuable retirement and related benefit rights.

The Public Employees' Pension Reform Act of 2013 (PEPRA), effective January 1, 2013, requires a CalPERS covered employer to determine the applicable PEPRA retirement benefit formula for new employees. CalPERS refers to all members that do not fit within the PEPRA definition of a "new member" as "classic members" who are subject to the Public Employees' Retirement Law (PERL). PEPRA allows a member after January 1, 2013, to retain his/her classic member retirement benefit status if the member continues his/her membership in all previous California Public Retirement System(s) by leaving his/her service credit and contributions (if any) on deposit, and the member enters into employment that results in CalPERS membership within six months of separating from the most recent California Public Retirement System. Classic member status also requires the membership date to be on or before December 31, 2012, in a California Public Retirement System in which reciprocity is established.

**Form Completion**

The form must be completed by:

1. All new hires effective on or after 01/01/13 who are CalPERS members.

2. Existing employees who become CalPERS eligible on or after 01/01/13. For example, part-time or intermittent employment exceeding 125 days (if paid on a per diem basis) or 1,000 hours within a fiscal year are covered by CalPERS retirement membership effective the beginning of the first pay period following the completion of 125 days or 1,000 hours of service, and therefore are now eligible for CalPERS on or after 01/01/13.

3. AC or designee must provide the Member Reciprocal Self-Certification Form to all new employees upon eligibility for membership.

4. AC or designee must sign and date the Member Reciprocal Self-Certification Form on the date the form is given to the employee.

5. Upon receipt of the completed Member Reciprocal Self-Certification Form, the AC will enter the date the employee returns the form.

6. The Member Reciprocal Self-Certification Form (PERS-CASD-801) must be submitted to your Personnel Specialist along with all other required hire documents.

# CalPERS Members Reciprocal Self-Certification Form (PERS-CASD-801) *Continue*

**Form Completed** Continue

7. The employee will be enrolled in to CalPERS membership based on the information provided on the form, myICalPERS will determine the retirement benefit formula.

8. The Member Reciprocal Self-Certification Form will be maintained in the employee official personnel file for audit purposes.

**Completing PERS-CASD-801**

| **Employee completes:** |
|---|
| • Last, First, Middle name<br>• Social Security number or CalPERs ID number<br>• Name of most reciprocal retirement system<br>• Permanent separation date form most recent reciprocal retirement system<br>• First membership date in any prior California public retirement system that is subject to reciprocity<br>• Check the applicable statement<br>• Sign and date |
| **AC or designee completes:** |
| • CalPERs membership eligibility date with our agency<br>• Original hire date with our agency<br>• Date member reciprocal self-certification form given to employee<br>• Date member reciprocal self-certification form received from employee<br>• Print designee of employer, title and date<br>• Designee's signature |
| **Personnel Specialist completes:** |
| • Name of CalPERs agency<br>• CalPERs business partner ID |

**Form Submission**

Personnel Transaction Unit will determine if the form must be submitted to SCO for Enrollment.

# CalPERS Members Reciprocal Self-Certification Form *Continue*

**Sample of PERS-CASD 801**

**California Public Employees' Retirement System**
P.O. Box 942709 Sacramento, CA 94229-2709
**888 CalPERS** (or **888**-225-7377)
TTY: (877) 249-7442 | Fax: (916) 795-4166
**www.calpers.ca.gov**

## RECIPROCAL SELF-CERTIFICATION FORM

*Complete the following information and return this form to your Personnel Office within 10 business days:*

| | | | |
|---|---|---|---|
| Employee Name | (Last) | (First) | (Middle) |
| Social Security Number or CalPERS ID Number: | | | |

SAMPLE

Check the applicable statement:

_____ I have not been a member of CalPERS or of a qualifying Public Retirement System in California.
_____ I was a member of CalPERS or a qualifying Public Retirement System in California and terminated my membership by withdrawing my funds.
_____ I am retired from CalPERS.
_____ I am retired from another Public Retirement System in California.
_____ I am an active member of CalPERS. I have funds on deposit with CalPERS.
_____ I am an active member of another Public Retirement System in California. (*Complete the box below*).

| | | |
|---|---|---|
| Name of Most Recent Reciprocal System: | Membership Date: | Separation Date: |
| Name of Prior Reciprocal System: | Membership Date: | Separation Date: |
| Name of Prior Reciprocal System: | Membership Date: | Separation Date: |

I understand that by accepting employment in a specific retirement system, I am subject to the applicable laws and regulations of that system. I also understand that completing this form does not constitute a request to establish reciprocity. I must complete and return the form ***Confirmation of Intent to Establish Reciprocity When Changing Retirement Systems*** to CalPERS.

I hereby certify that the foregoing information is true and correct and any information found to be incorrect may require corrections to my account in the California Public Employees' Retirement System including, but not limited to, my date of membership. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

_____ _____
Employee Signature Date

***TO BE COMPLETED BY EMPLOYER ONLY:***

| | | |
|---|---|---|
| Name of CalPERS Agency: | CalPERS Business Partner ID: | Employees' CalPERS Original Hire Date: |
| Designee of Employer: (Print Name) | (Title) | Employees' CalPERS Membership Eligibility Date: |
| Designee's Signature: | | (Date) |

**The employer must retain this form in the employee's file for auditing purposes.**

# Designation of Person Authorized to Receive Warrant (STD 243)

The Designation of Person Authorized to Receive Warrants (STD.243) is required for employees new to State service and reinstatements. It is optional for transfers from another State agency or promotions. If the employee has an address change, a new STD 243 is required.

In accordance with Government Code 12479, the person listed as the designee will receive the employee's final pay warrant upon death. The designation remains in effect until the employee changes the designation or permanently separates from State service.

The designee must be 18 years of age or older.

**Attendance Clerk responsibilities**

All DGS AC's are expected to follow the steps outlined below:

- review the STD 243 for accuracy & completeness
- return the original STD 243 and one copy with original signatures to your PS (if new to state send along with the Date of Appointment Document Checklist)

The PS will sign the agency section and forward the one copy to the employee. The original will be filed in the employee's OPF.

**Completing the Designation of Person Authorized to Receive Warrant**

The employee will complete the STD 243. As it is a legal document, you are responsible that the following criteria are met:

- Document is completed in ink or typed
- Original and one copy both must have the employee's original signature
- Full legal names for the employee and the designee are used
- No erasure or corrections are made to the designee section of the Warrant Designee. If this should happen, the employee needs to fill out a new form. Destroy the old one
- The STD 243 must be updated if the employee has a name change, address change or there is a change of the beneficiary designation. For example: the warrant designee or beneficiary changes due to death, separation or divorce

***Note:*** **Advise the employee to read the instructions and Privacy Notice on the Warrant Designee.**

# Designation of Person Authorized to Receive Warrant (STD 243)

**Sample of STD 243**
**Form is available at:** www.osp.dgs.ca.gov.

Print Clear

STATE OF CALIFORNIA – STATE CONTROLLER'S OFFICE

**DESIGNATION OF PERSON(S) AUTHORIZED TO RECEIVE WARRANTS**
**(GC § 12479)**
STD. 243 (REV. 08/01)

EMPLOYEE NAME (First, Middle, Last)

| NAME OF EMPLOYING STATE AGENCY | AGENCY LOCATION (City) |
|---|---|
| | |

SAMPLE

Pursuant to Section 12479 of the Government Code, I hereby designate the following person(s), trust, estate, or corporation which, notwithstanding any other provision of the law, shall be entitled upon my death to receive [illegible] warrants that would have been payable to me had I survived.
*NOTE: Direct deposit payments are not subject to this [illegible]*

**Important:** This is NOT a designation for payment of death benefits or refund of employee retirement contributions. A form PERS-BSD-241, Beneficiary Designation, must be completed to file a designation with the California Public Employees' Retirement System for death benefits.

**PRIMARY DESIGNEE** *(Must be 18 years of age or older)*

| PRIMARY DESIGNEE NAME (First, Middle, Last) | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
|---|---|---|
| ADDRESS | CITY AND STATE | ZIP CODE |

**CONTINGENT DESIGNEE(S)** *(Must be 18 years of age or older)*

| FIRST CONTINGENT DESIGNEE NAME (First, Middle, Last) | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
|---|---|---|
| ADDRESS | CITY AND STATE | ZIP CODE |
| SECOND CONTINGENT DESIGNEE NAME (First, Middle, Last) | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
| ADDRESS | CITY AND STATE | ZIP CODE |
| THIRD CONTINGENT DESIGNEE NAME (First, Middle, Last) | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
| ADDRESS | CITY AND STATE | ZIP CODE |

I hereby revoke all designations that I have previously filed.

The primary designated person shall be the designated person that receives the warrants. If the primary designated person predeceases the employee, the next designated person who survives the employee will receive the warrant(s).

If the above-named designee does not file a written request with the personnel/payroll office of my employing state agency/campus for such warrants within sixty (60) days after the date of my death, this designation shall be and become null and void.

This designation will remain in full force and effect during my employment with any California state agency/campus until revoked in writing by me.

| EMPLOYEE HOME ADDRESS | |
|---|---|
| CITY, STATE, ZIP CODE | |
| EMPLOYEE SIGNATURE (Please sign in ink) ▶ | DATE SIGNED |

**FOR AGENCY/CAMPUS USE ONLY**

REVIEWED BY THE PERSONNEL/PAYROLL OFFICE AND FILED

| SIGNATURE OF AUTHORIZED OFFICER ▶ | |
|---|---|
| TYPED NAME | DATE |

***INSTRUCTIONS***

1. Complete this form; print clearly in ink or type all information requested.
2. Show the full name of all designees; for example, "Mary Jane Smith", not Mrs. John E. Smith.
3. Specify the relationship of each person designated, such as wife, husband, domestic partner, daughter, son, mother, father, parent, friend, etc.
4. Verify that the form is complete and correct. No erasures or corrections may be made in the name of the primary designee or contingent(s). If any error has been made, complete a new form.
5. Sign the form in ink and submit to your personnel/payroll office. A copy will be returned to you for your records.
6. You may change your designation at any time by filing a new form STD. 243 with your personnel/payroll office.
7. You may completely revoke a designation at any time by submitting either of the following with original signature: A new form STD. 243 indicating "NONE" for the primary designee name or a letter to your employer.
8. Inform your personnel/payroll office when a change occurs in your primary designee's or contingent's address.
9. You may wish to file a new designation upon any change in your marital or domestic partnership status.

# Emergency Information/Physician Designation (DGS OHR 20)

The Emergency Information/Physician Designation (DGS OHR 20) is required for new hires to State service, reinstatements and transfers from another State agency.

The employee should indicate who should be notified in case of an emergency and choice of medical treatment. It is important that the information is current at all times.

The Attendance Clerk should review the Emergency Information for clarity. Make 2 copies of the Emergency Information form; the original must be submitted to the PS with the Date of Appointment Checklist and filed in the employee's OPF. You may distribute the remaining copies: one will remain in the office and the other copy goes to the employee.

| | |
|---|---|
| **Emergency Information** | Employee shall enter:<br>• Full name<br>• Home telephone number<br>• Home address (street, city, zip code)<br>• Cell number<br>• Office*:* work site. E.g., Office of Human Resources<br>• Unit: e.g., Personnel Transaction Unit<br>• Birthdate: date of birth |
| **Person To Notify In Case Of Accident** | Employee must designate a person(s) to notify in case of an emergency. Employee shall enter:<br>• Name*:* designee's name<br>• Relationship*:* designee's relationship to employee<br>• Address<br>• Telephone number<br>• City, State, Zip: designee's address<br>• Cell number: designee's phone number |
| **Physician Designation** | If employee chooses not to designate a physician, first box needs to be checked.<br>If employee chooses to designate a physician, the following must be completed:<br>• Second box is checked<br>• Physician name or medical group<br>• Telephone number<br>• Office address: designate physician information<br>• Hospital preference: hospital where treatment would be administered<br>• Health Plan/Id number (Insurance carrier)*:* employee health coverage<br>• Employee's signature*:* employee shall sign and date form |

# Emergency Information/Physician Designation (DGS OHR 20) Continue

**Sample of DGS OHR 20**

STATE OF CALIFORNIA
**EMERGENCY INFORMATION / PHYSICIAN DESIGNATION**
DGS OHR 20 (Rev. 7/14)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

**CONFIDENTIAL**

Please submit completed forms to your supervisor. Supervisors will retain the original and forward a copy to the Office of Human Resources for inclusion in your official personnel file. Submit a new form to your supervisor immediately when information listed below changes. If you have a chronic medical problem (i.e. a heart condition, epilepsy, asthma, diabetes, etc.) that could incapacitate you during work hours, you are encouraged to discuss symptoms and emergency treatment with your supervisor.

## EMERGENCY INFORMATION

*Please Print or Type*

| | |
|---|---|
| EMPLOYEE NAME (Last, First, Middle Initial) | HOME TELEPHONE NUMBER |
| HOME ADDRESS (Number and Street) (City, State) (Zip Code) | MOBILE PHONE NUMBER |
| OFFICE UNIT | BIRTHDATE |

SAMPLE

| Person(s) to notify in case of accident or illness | | | |
|---|---|---|---|
| | NAME | RELATIONSHIP | |
| | ADDRESS | | TELEPHONE NUMBER |
| | CITY, STATE | ZIP CODE | MOBILE PHONE NUMBER |
| | NAME | RELATIONSHIP | |
| | ADDRESS | | TELEPHONE NUMBER |
| | CITY, STATE | ZIP CODE | MOBILE PHONE NUMBER |

## PHYSICIAN DESIGNATION

In case of injury of sudden job-related illness, employees are given the option of choosing their own personal physician to administer medical treatment or accepting services provided by the department. "Personal Physician" means the employee's regular physician and surgeon who has previously directed the medical treatment of the employee and who retains the employee's medical records. The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

☐ *I decline designating a personal physician AND will accept medical treatment from the department's designated medical facility.*

☐ *If I am injured on the job, I wish to be treated by my personal physician or my personal physician's integrated multi-specialty medical group, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician or integrated multi-specialty medical group; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my pre-designated physician.*

| | |
|---|---|
| PHYSICIAN'S NAME AND/OR NAME OF PERSONAL PHYSICIAN'S MULTI SPECIALTY MEDICAL GROUP | TELEPHONE NUMBER |
| OFFICE ADDRESS | |
| HOSPITAL PREFERENCE | HEALTH PLAN/ID NUMBER |

**EMPLOYEE'S SIGNATURE** **DATE SIGNED**

**I am the above employee's regular, primary care physician. I have previously treated and do retain his/her medical records and I agree to treat the above employee for a work related injury and/or illness.**

**PHYSICIAN'S SIGNATURE** or designated employee of the physician's medical group **DATE SIGNED**

# Incompatible Activity Statement

It is the policy of DGS to provide civil service employees and exempt officers with guidelines concerning activities which are incompatible with state employment.

The purpose of the policy is to protect the integrity established by employees in carrying out the Department's responsibilities to other State agencies and to the public.

The Incompatible Activity Statement is required for all initial appointments, change in classification, and change in duties or circumstances that potentially conflicts with the policy.

Advise the employee to read the statement before signing the certification on the last page of the booklet. If the signature is not legible, print or type the employee's name below the signature line. Do not use a pencil.

The original signed "Certification" (the last page of the booklet) must be signed by the employee and returned to the PS with the Date of Appointment Checklist. The original will be filed in the employee's OPF. The employee will keep the booklet.

# Incompatible Activity Statement *Continue*

**Sample**

**CERTIFICATION:**

The following certification is to be signed and submitted by officers and employees to comply with the Incompatible Activity Statement in accordance with the Department of General Services policy, Government Code Section 19990, and applicable Memoranda of Understanding.

SAMPLE

**CERTIFICATION**

I have received and read a copy of the Incompatible Activity Statement of the Department of General Services.

| | |
|---|---|
| Signature | Date |
| Typed or Printed Name | |
| Classification Title | Position Number |
| Office/Division | |

Filing certification due to:

- ☐ Initial appointment
- ☐ Change in classification
- ☐ Change in duties or circumstances that raise the issue of potential conflict with this policy

After completion, detach this page and submit it to your Attendance Clerk for processing.

# Military Service Declaration (STD 912)

The Military Service Declaration (STD.912) is required for new hires to State civil service and reinstatements. The employee's response to the Military Service Declaration is voluntary.

The information provided can be used by the Testing Unit to verify veteran's status for open examinations.

The information provided is confidential.

The original Military Service Declaration must be returned to your PS with the Date of Appointment Document Checklist. The original is filed in the employee's OPF.

**Completing the STD 912**

| |
|---|
| **You shall type or print:**<br>• To: Employee's name<br>• Date: Date completed |
| **Employee shall:**<br>• 1. Check "yes" or "no"<br>• 2 – 6. Complete if answer to #1 was "yes" |
| **Employee shall:**<br>• sign and date |

If the employee does not complete the form, make a notation on the document before submitting it to PTU.

# Military Service Declaration (STD 912) *Continue*

**Sample of STD 912**

**Form is available at:** www.osp.dgs.ca.gov.

Clear Print

STATE OF CALIFORNIA

## MILITARY SERVICE DECLARATION

STD. 912 (NEW 7-94)
*(Formerly DPA 190)*

*See Privacy Notice Below*

| TO: | FROM: PERSONNEL OFFICE | DATE |
|---|---|---|

**Some military service qualifies State employees for certain benefits during their careers with the State of California. In order for us to determine if you will qualify for any benefits, please complete, sign, and return this Declaration immediately.**

1. Did you serve on **ACTIVE** duty in the armed forces? ☐ YES ☐ NO

IF YOUR ANSWER TO #1 IS "YES", PLEASE COMPLETE THE REMAINDER OF THE DECLARATION.
IF YOUR ANSWER TO #1 IS "NO", PLEASE SIGN, DATE, AND RETURN THE DECLARATION.

SAMPLE

2. List your Active Duty

| ARMED FORCES BRANCH | ENTRY DATE | RELEASE DATE | RELEASE TYPE | | |
|---|---|---|---|---|---|
| | | | HONORABLE | DISHONORABLE | OTHER |
| | | | | | |
| | | | | | |
| | | | | | |

3. List any campaign medals that you received

4. Did you, on, or after the first day of January 1956 voluntarily extend your original term of enlistment, service, or other tour of duty? ☐ YES ☐ NO

5. Were you, on January 1, 1956, on an indefinite tour of duty or tour of duty in excess of four years? ☐ YES ☐ NO

6. Did you, after January 1, 1956, serve a tour of duty in excess of four years? ☐ YES ☐ NO

If the answer to any of Items 4, 5, or 6 is "YES", explain the circumstances.

*I hereby certify that, to the best of my knowledge, the above information on this Declaration is true and correct.*

| SIGNATURE | DATE SIGNED |
|---|---|
| | |

**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.

Legal refereances authorizing maintenance of this information include Government Code Sections 19771-19786, 19815.4, 19816, 19816.2, and 19816.6. Sections 395.1 of the Military and Veterans' Code governs the rights and benefits of State Civil Service employees.

Information requested on this form is used by Personnel Offices for benefits due to veterans. **There is no disclosure of this information.** It is voluntary to furnish all information requested on this Declaration. Failure to provide the information may result in certain benefits not being processed or being processed incorrectly.

Employees have the right of access to copies of their Military Service Declaration upon request. The official responsible for the maintenance of this Declaration is your current Personnel Officer

# Employee Asbestos Notification (STD 250)

The Employee Asbestos Notification (STD.250) is required for all employees new to state as a building containing asbestos. Your supervisor can advise you if the building(s) in your unit contain asbestos.

State agencies that occupy buildings constructed prior to 1979, and know of the presence of asbestos materials in the building, are required to provide written notification to employees working in the building.

Each office, board or commission shall provide the employee locations of asbestos in the building(s) in which the employee works.

The original Employee Asbestos Notification is to be submitted with the Date of Appointment Checklist to the PS. The notification must be given to the employee within 15 days of date of appointment. The original is filed in the employee's OPF.

Advise the employee to read the notification before signing.

| |
|---|
| **You shall enter:**<br>• Department name and full address of the building where employee works |
| **You shall enter:**<br>• Full address of the building manager maintaining the asbestos information |
| • Type or print employee's name |
| **Employee:**<br>• Will sign and date |

# Employee Asbestos Notification (STD 250) *Continue*

**Sample of STD 250**

The form is available at: www.osp.dgs.ca.gov

Clear Print

STATE OF CALIFORNIA - GENERAL SERVICES HUMAN RESOURCES

**EMPLOYEE ASBESTOS NOTIFICATION**

STD. 250 (REV. 3/2002)

DEPARTMENT NAME

This is to notify employees working at:

ADDRESS

Effective January 1, 1989, Assembly Bill 3713, Chapter 1502, Statutes of 1988, Health and Safety Code, Subsection 25915 et seq., requires State agencies which occupy buildings constructed prior to 1979, and know of the presence of asbestos-containing materials (ACM) in the building to provide written notification to employees within 15 days of knowledge. Employees new to the building shall be provided this information within 15 days of commencing work in the building. Please refer to the State Administrative Manual Section 2591.

SAMPLE

Airborne asbestos levels in buildings are much lower than those in industrial workplaces where serious health effects such as lung cancer and asbestosis have been observed. However, it is important for employees to follow proper work practices to minimize the potential for disturbing ACM. Avoid touching asbestos materials on walls, ceilings, pipes, or boilers. Do not drill holes, hang plants or other objects from walls/ceilings made of ACM. Do not disturb ACM when replacing light bulbs. **If you find ACM that has been damaged, report it to your supervisor. Do not disturb damaged asbestos material or asbestos debris.** Only persons authorized and properly trained should perform any work which may disturb asbestos materials.

Asbestos-containing materials pose no threat to your health unless asbestos fibers become airborne due to material aging, deterioration, or as the result of some damage. Asbestos conditions may vary, and where ACM have been identified in State building surveys, the materials were generally in good condition, enclosed, encapsulated, or of a type not likely to release fibers unless disturbed.

Any employee may review the asbestos survey report, results of bulk sampling, or air monitoring conducted in this building. All asbestos-related data will be available during normal business hours at the building manager's office located at: DEPARTMENT NAME

ADDRESS

I, _____, have read and received a copy of the Employee
(Please Print Name)
Asbestos Notification.

EMPLOYEE SIGNATURE DATE

**DISTRIBUTION:** ORIGINAL - PERSONNEL FILE, COPY - EMPLOYEE

# Anti-Discrimination Memo (AO 15-01)

It is DGS policy to take all reasonable steps to prevent discrimination and harassment from occurring. This includes, but is not limited to, providing discrimination and harassment prevention training to all employees, and supervisors/managers on their responsibilities to enforce the DGS policy on discrimination and harassment. It is DGS policy to provide a copy of this policy to new employees to State service, reinstatements and transfers from another State agency. Employees are required to read DGS' Administrative Order 15-01 and sign the Acknowledgement of Receipt.

The original Acknowledgement of Receipt signed by the employee is to be submitted to OHR with the Date of Appointment Checklist to the PS.

The original will be filed in the employee's OPF.

The Administrative Order 15-01 memo and Acknowledgement of Receipt are on DGS' Intranet site: http://inside.dgs.ca.gov/ad/ao.aspx

# Anti-Discrimination Memo (AO 15-01) *Continue*

**Sample of AO 15-01**

| | |
|---|---|
| STATE OF CALIFORNIA<br>DEPARTMENT OF GENERAL SERVICES | DATE ISSUED: February 6, 2015 |
| **Administrative Order 15-01** | EXPIRES:<br>Until Rescinded |
| TO:<br>**All DGS Employees**<br><br>SUBJECT:<br>**ANTI-DISCRIMINATION POLICY** | REFERENCES:<br>Title VII of the Civil Rights Act of 1964, Americans with Disabilities Act of 1990, as amended, the Age Discrimination in Employment Act (ADEA), Genetic Information Nondiscrimination Act of 2008 (GINA), Fair Employment and Housing Act (FEHA) |
| | SUPERSEDES:<br>AO 06-02 |

SAMPLE

**Purpose**

This Administrative Order updates Department of General Services (DGS) staff about federal and state anti-discrimination laws in the workplace. DGS is subject to Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, as amended, the Age Discrimination in Employment Act (ADEA), Genetic Information Nondiscrimination Act of 2008 (GINA), Fair Employment and Housing Act (FEHA), and all other rules and regulations that are applicable.

**Policy**

DGS does not tolerate discrimination, harassment or retaliation in the workplace. This includes discrimination or harassment on the basis of:

- age (40 and over),
- color,
- disability (physical, and mental, including HIV and AIDS),
- gender/gender identity,
- genetic information,
- ancestry,
- national origin (including language use restrictions),
- marital status,
- political affiliation,
- race,
- religion,
- medical condition (cancer and genetic characteristics),
- sexual orientation,
- pregnancy,
- child birth or related medical conditions,
- Vietnam era and military or veteran status,
- victims of domestic violence,
- use of Family and Medical Care Leave, or
- any other basis protected by law.

# Sexual Harassment Memo (AO 15-02)

It is the policy of the Department of General Services (DGS) that sexual harassment is unacceptable behavior in the workplace and will not be condoned. Supervisors/managers are responsible for maintaining a favorable working atmosphere free from sexual harassment for all employees.

New employees to State service, reinstatements and transfers from another State agency are required to read DGS' Administrative Order 15-02 and sign the Acknowledgement of Receipt. It is not required for Boards and Commissions.

The original Acknowledgement of Receipt signed by the employee is to be submitted to OHR with the Date of Appointment Checklist to the PS.

The original will be filed in the employee's OPF.

The Administrative Order 15-02 memo and Acknowledgement of Receipt are on DGS' Intranet site: http://inside.dgs.ca.gov/ad/ao.aspx

**Completion of AO 15-02**

| | |
|---|---|
| **Date** | • Date signed |
| **Employee's Name** | • Print full name |
| **Employee's Signature** | • Signature in ink |
| **Office** | • e.g., Office of Human Resources (OHR) |

# Sexual Harassment Memo (AO 15-02) *Continue*

## Sample of AO 15-02

| STATE OF CALIFORNIA<br>DEPARTMENT OF GENERAL SERVICES | DATE ISSUED:<br>February 6, 2015 |
|---|---|
| **Administrative Order 15-02** | EXPIRES<br>Until Rescinded |
| TO: **ALL DGS EMPLOYEES** | REFERENCES:<br>Title VII of the Civil Rights Act of 1964<br>Fair Employment and Housing Act (FEHA) |
| SUBJECT: **SEXUAL HARASSMENT PREVENTION POLICY** | SUPERSEDES:<br>**AO 06-03** |

SAMPLE

**Purpose**

This Administrative Order informs Department of General Services (DGS) staff about the department's policy regarding sexual harassment or sexual harassing behavior, conduct or comments in the workplace. DGS is subject to Title VII of the Civil Rights Act of 1964, the Fair Employment and Housing Act (FEHA) and all other rules and regulations that are applicable.

**Policy**

It is the policy of DGS that all employees have a right to work in an environment free from all forms of discrimination, including sexual harassment, intimidation, retaliation or coercion. DGS is committed to providing a work environment free from sexual harassment. Sexual harassment is a form of sex discrimination that illegal under both state and federal law. It is prohibited by Title VII of the Civil Rights Act of 1964, as amended, and the Fair Employment and Housing Act (FEHA). The prohibition against discrimination, sexual harassment and sexual harassing behavior, conduct or comments applies to all levels and areas of operations and programs, staff, volunteers, vendors and contractors.

It is DGS policy to take all reasonable steps to prevent sexual harassment from occurring. This includes, but is not limited to providing:

- Sexual harassment prevention training to all employees;
- Providing training to supervisors/managers on their responsibilities to enforce the DGS policy on sexual harassment;
- Counseling; and
- A departmental discrimination complaint process administered by DGS' Equal Employment Opportunity Office (EEO).

It is DGS policy to provide a copy of this policy to new employees.

**Who is Affected**

All DGS employees are held accountable for ensuring that discrimination, including sexual harassment does not occur by complying with the conduct criteria set forth in this policy and by conducting themselves in a respectful and professional manner.

# Union Information Package

Union Information packages are required for new rank and file (“R”) employees whenever the Memorandum of Understanding (MOU) states the employer is responsible for providing the employee with a union information package. Employees who move into one of the following Collective Bargaining Id’s must be provided with the Union package: R01, R02, R04, R11, R12, R14 R15, and R20.

Union information may be obtained from the specific union.

OHR does not require acknowledgement. The original is not filed in the employee’s OPF.

You may order the Union Information Package through the appropriate union.

# Health/Dental/Vision

Refer to the “Employee Benefits” of the AC Manual

# Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA) was enacted in March 2010 to ensure that individuals have access to quality and affordable health care. There are several provisions of the ACA that impact employers, such as the State of California.

The ACA requires employers to provide notices to employees with information about the Health Insurance Marketplace, known as Covered California, and employer-sponsored health coverage.

### Attendance Clerks Responsibility

In 2013, the state implemented the *Health Insurance Marketplace Coverage Options Notice* requirements. AC's are required to provide this Notice to ALL new employees, regardless of their health plan enrollment or eligibility status, within 14 days of the employee's hire date.

The ACA requires group health plans, health plan administrators, and employers to issue a *Summary of Benefits and Coverage Notice* to employees eligible for health coverage with information on the health plan options available to them so they can make informed decisions about the health plan they choose

Attendance Clerks (AC) are required to issue the Summary of Benefits and Coverage Notice to all employees newly eligible for health benefits no later than the first day the employee is eligible to enroll in health coverage.

*For example, if a health benefit-eligible employee is hired on August 12, departments must provide this Notice, along with the health enrollment forms (HBD-12 and HBD-12A) to the employee no later than September 1.*

To ensure the timely distribution of the *Health Insurance Marketplace Coverage Options* and *Summary of Benefits and Coverage Notices*, CalHR has developed the *ACA Notification Checklist* (CalHR Form 782). AC's must use this form to document the distribution of these notices. The two-part Checklist includes the following:

- **Part I** documents the distribution of the legally required *Health Insurance Marketplace Coverage Options Notice*. This section must be completed by the AC's responsible for providing the Notice to a newly hired employee within 14 days of the employee's hire date.
- **Part II** documents the distribution of the *Summary of Benefits and Coverage Notice* along with the health benefit enrollment forms (HBD 12 and HBD 12A) to employees newly eligible for health benefits. This section must be completed by the AC's representative responsible for providing the Notice and enrollment forms to the employee.

# Affordable Care Act (ACA) *Continue*

**Instructions**

The Affordable Care Act (ACA) Notification Checklist is mandatory for all new employees hired (or who become eligible) after January 1, 2015. The top section has space to complete the employee's name, hire date, position number, social security number and tenure/time base.

**Part I**: Document the date the notice was given to the employee about the *Health Insurance Marketplace Coverage Options and Health Cover Notice.* This is a one-time notice that must be given to every new employee to your department/agency within 14 days of their hire date.

**Part II**: If the employee is eligible for health benefits, the employee must be provided with three forms:

1. The new form Summary of Benefits and Coverage,
2. Health Benefits Enrollment (HBD 12), and
3. Declaration of Health Coverage (HBD 12A)

Health benefit documents must now be provided to a newly eligible employee by the first day the employee is eligible to enroll in coverage.

It is imperative ALL new to state hire packets must contain the documents mentioned above and be submitted to OHR after completion.

**Failure to comply with the Employer Shared Responsibility provisions could result in significant penalties to the State!**

For additional information on the ACA's Employer Shared Responsibility provisions, please refer to the Internal Revenue Code §4980H.

# Affordable Care Act (ACA) *Continue*

## New Health Insurance Marketplace Coverage Options Notice

**Sample**

DGS CALIFORNIA DEPARTMENT OF GENERAL SERVICES

Governor Edmund G. Brown Jr.

### New Health Insurance Marketplace Coverage Options and Your Health Coverage Notice

SAMPLE

#### PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employer based health coverage offered by your employer. Receipt of this notice does not confirm you are eligible for health coverage by your employer. Please refer to Part B below and to your departmental Human Resources Officers for eligibility requirements.

#### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace in California is known as "Covered California." Covered California offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage though Covered California begins in October 2013, for coverage starting as early as January 1, 2014.

#### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

#### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through Covered California and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your

**Office of Human Resources** | *State of California | California Government Operations Agency*
*707 3rd Street, 7th Floor | West Sacramento, CA 95605 | t 916.376-5400 f 916.376-5390*

# Affordable Care Act (ACA) *Continue*

## Summary of Benefits and Coverage Notice

## Sample

DGS CALIFORNIA DEPARTMENT OF GENERAL SERVICES

Governor Edmund G. Brown Jr.

### 2015 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, and in accordance with the Affordable Care Act, each health plan available to you through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). The SBC provides important information to help you better understand your health benefit coverage and make efficient choices among health plan options.

SAMPLE

To view the SBC online, visit www.calpers.ca.gov or any of the health plan websites below. To request a free copy of the SBC, please contact the health plan directly.

**Anthem Blue Cross**
(855) 839-4524
www.anthem.com/ca/calpershmo

**Blue Shield of California**
(800) 334-5847
www.blueshieldca.com/calpers

**California Association of Highway Patrolmen (CAHP)***
(800) 734-2247
www.thecahp.org

**California Correctional Peace Officers Association (CCPOA)***
(800) 257-6213
www.ccpoabtf.org

**Health Net of California**
(888) 926-4921
www.healthnet.com/calpers

**Kaiser Permanente**
(800) 464-4000
www.kp.org/calpers

**Peace Officers Research Association of California (PORAC)***
(800) 288-6928
www.porac.org

**PERS Select, PERS Choice, and PERSCare**
(877) 737-7776
www.anthem.com/ca/calpers

**Sharp Health Plan**
(855) 995-5004
www.sharphealthplan.com/calpers

**United Healthcare**
(877) 359-3714
www.uhc.com/calpers

*To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

Please contact your department's Human Resources Office with questions regarding eligibility and enrollment.

Administration Division, Office of Human Resources | State of California | California Government Operations Agency
707 3rd Street, 7th Floor | West Sacramento, CA 95605 | t 916.376-5000 f 916.376-5018

# Affordable Care Act (ACA) Notification Checklist

**Sample of CalHR 782**

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

## Affordable Care Act (ACA) Notification Checklist

California Department of Human Resources
State of California

Print Form | Reset Form

This checklist is intended to document and ensure that departments/agencies are providing the legally required notices to employees for compliance with the ACA.

**PART I** documents the distribution of the legally required Health Insurance Marketplace Coverage Options Notice to newly hired employees.

**PART II** documents and tracks the distribution of the legally required Summary of Benefits and Coverage Notice and the health benefit status for employees newly eligible for health benefits. Both Parts I and II must be completed.

SAMPLE

**Upon completion, this document must be retained in the employee's Official Personnel File.**

### Employee Information

Employee Name | Hire Date

Position Number | Social Security Number | Tenure/Time Base

### Part I - New Employees

The Health Insurance Marketplace Coverage Options and Health Coverage Notice is required to be provided to every new employee in your department/agency within 14 days of their hire date.

Date Provided | Department Representative

### Part II - Employees Newly Eligible for Health Benefits

Health benefit documents to be provided to employees newly eligible for health benefits by the first day the employee is eligible to enroll in coverage (e.g., employee is hired on August 12, the following documents must be provided to employee no later than September 1, the earliest effective date of coverage).

1. Is employee newly eligible for health benefits? ☐ If Yes, go to question 2. If No, no further action required.

2. Provide the following forms:

- ☐ Summary of Benefits and Coverage Notice
- ☐ Health Benefits Enrollment (Form HBD-12)
- ☐ Declaration of Health Coverage (Form HBD-12A)

Date Provided | Department Representative

### Human Resources Office use Only

I certify that data stated herein is correct, complete, and in accordance with all laws and regulations.

Department/Agency Name | Contact Number

Reviewer's Printed Name | Reviewer's Signature | Date

CalHR 782 | Page 1 of 1 | (rev 03/2016)

# Dependent Eligibility Verification Checklist (CalHR 781)

The *Dependent Eligibility Verification Checklist* (CalHR Form 781) was developed to facilitate documentation and administration of dependent enrollments. Departments are responsible for monitoring eligibility for employees and their dependents, and to hold employees accountable for failure to notify their Human Resources office in writing within 60 days of a change to dependent eligibility. Employees may be held accountable if any documentation is determined to be inaccurate or fraudulent or for failure to notify OHR of changes to dependent eligibility. This may include reimbursing their employer, the health, dental, and/or vision benefit plan, and/or the CalPERS system for expenditures incurred for medical claims, processing fees, administrative expenses, and attorney's fees on behalf of any ineligible family member, and disciplinary action.

The California Department of Human Resources (CalHR) may monitor eligibility and enrollment processes and may hold departmental management and/or employees accountable for compliance.

Government Code section 20128 of the California Public Employees' Retirement Law grants California Public Employees' Retirement System (CalPERS) the authority to require information it deems necessary to determine a member's or beneficiary's entitlement to benefits. As such, departments are responsible for requesting additional information and supporting documentation, as necessary, to substantiate dependent eligibility for health benefits. Dental and vision eligibility is also subject to this requirement, as set forth in state collective bargaining agreements (for excluded employees, Government Code § 22952 and California Code of Regulations, title 2, § 599.927).

### Attendance Clerks/Personnel Liaisons

The ACs/PLs are to provide employees with the Checklist for every enrollment transaction that involves adding dependents to the health and dental benefit roll and for annual recertification of parent-child relationship (PCR) dependents. Employees must complete and sign their portion of the Checklist and submit it to the Office of Human Resources (OHR) with the required documentation to substantiate dependent eligibility. OHR will complete Section 3 of the Checklist and retain the document in the employee's Official Personnel Folder (OPF).

The Checklist must also be completed when dependent enrollments are processed for the Premier Vision Plan. Documentation must be provided and all sections of the Checklist must be completed by the appropriate parties before OHR can enroll dependents.

### Employees

Employees are required to complete this form when adding dependents to health or dental coverage, as well as vision coverage processed through departmental Human Resources offices, and when an employee annually recertifies their parent-child relationship with enrolled dependents. By completing this form, employees are certifying the information submitted is true and accurate to the best of his/her knowledge.

# Dependent Eligibility Verification Checklist (CalHR 781) *Continue*

**Instructions**

***Section 1 –*** contains a chart that defines the dependents eligible for health, dental, and vision coverage and the required enrollment forms and acceptable documentation necessary to substantiate dependent eligibility:

**Dependent Type:** According to dependent type (e.g., spouse/registered domestic partner, disabled adult child, PCR), there may be specific requirements necessary to substantiate eligibility.

**Required Enrollment Forms**: This section identifies the forms required to enroll dependents into health, dental, or vision coverage. Additional documentation is required to substantiate dependent eligibility and is outlined in the *Acceptable Document(s) to Verify Eligibility* section.

**Acceptable Document(s) to Verify Eligibility:** This section identifies documents necessary to substantiate dependent eligibility. In some cases, multiple documents may be required. These requirements are specified for each dependent type.

***Section 2 –*** requires the employee to certify, under penalty of perjury, the information submitted is true and accurate to the best of his/her knowledge. It includes several statements, each of which must be initialed by the employee, acknowledging the employees obligations.

***Section 3 –*** This section requires OHR staff to certify that the necessary documentation was reviewed to verify dependent eligibility prior to enrollment. It includes several statements, each of which must be initialed by staff completing the Checklist. By initialing and signing this section, the Personnel Specialist is certifying they have received supporting documentation to verify dependent eligibility.

**Personnel Specialist**
PS must provide a copy of the completed, signed Checklist to the employee. The Checklist must also be retained in the employee's OPF along with current enrollment forms and supporting documentation used to substantiate dependent eligibility.

When an employee transfers departments, proper retention of these documents enables the receiving department's human resources staff to see that all required documentation was submitted and reviewed prior to enrollment.

**Additional Information**
For more information on the state's health eligibility rules and enrollment process, refer to CalPERS' Policies and Procedures page on-line at www.calpers.ca.gov. Additional information on either the dental or vision benefit programs can also be found online at www.calhr.ca.gov

# Dependent Eligibility Verification Checklist (CalHR 781) *Continue*

**Sample of CalHR 781 – page 1**

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Print Form
Reset Form

## Dependent Eligibility Verification Checklist

California Department of Human Resources
State of California

SAMPLE

Employee Name: Department Name:

| Dependent Name | Dependent Type |
|---|---|
| | |
| | |
| | |

Employees and departmental human resources (HR) staff are required to complete this form when adding dependents to health, dental or vision coverage processed through departmental HR offices, and when an employee annually recertifies their parent-child relationship with enrolled dependent. By completing this form, employees are certifying the information submitted is true and accurate and HR staff are certifying that they have received and reviewed supporting documentation to verify an employee's dependent eligibility. The following chart defines the dependents eligible for health, dental, and premier vision plan coverage and acceptable documents to verify respective eligibility. HR staff must use this form to indicate which documents were provided by the employee to determine their dependent(s) eligibility.

### Section 1. Required and Acceptable Forms and Documents for Determining Dependent Eligibility

**Spouse/Registered Domestic Partner**

| Required Enrollment Forms | Acceptable Document(s) to Verify Eligibility |
|---|---|
| Health:<br>☐ Health Benefit Plan Enrollment Form (HBD-12)<br>☐ Declaration of Health Coverage (HBD-12A)<br><br>Dental:<br>☐ Dental Plan Enrollment Authorization (STD. 692)<br><br>Vision:<br>☐ Premier Vision Plan Enrollment Authorization (CalHR 774) | ☐ Marriage Certificate/Declaration of Domestic Partnership or Certificate of Registry of Marriage (must be issued within the last 6 months); or,<br>☐ Affidavit of Marriage/Domestic Partnership (CalPERS Form HBSD-1965)<br><br>And one of the following:<br>☐ Copy of front page of most recent federal or state income tax return (confirming dependent as spouse); or<br><br>A document dated within the last 60 days showing current relationship status (document must list employee's name, spouse's name, address, and date), such as:<br>☐ Household bill or statement of account; or<br>☐ Other (e.g., life or auto insurance policy): |

**Children* up to age 26 (the month in which dependent attains age 26)**
*Natural-born, adopted, placement for adoption, step, or registered domestic partner's children.

| Required Enrollment Forms | Acceptable Document(s) to Verify Eligibility |
|---|---|
| Health:<br>☐ Health Benefit Plan Enrollment Form (HBD-12)<br>☐ Declaration of Health Coverage (HBD-12A)<br><br>Dental:<br>☐ Dental Plan Enrollment Authorization (STD. 692)<br><br>Vision:<br>☐ Premier Vision Plan Enrollment Authorization (CalHR 774) | ☐ Birth Certificate; or,<br>☐ Official Hospital Birth Record (e.g., Certificate of Live Birth); or,<br>☐ Adoption Certificate naming employee, spouse, or domestic partner, as the child's parent; or,<br>☐ Court order naming employee, spouse, or domestic partner, as the child's legal guardian. |

CalHR 781 Page 1 of 4 (rev 06/2016)

# Dependent Eligibility Verification Checklist (CalHR 781) *Continue*

**Sample of CalHR 781 – page 2**

| **Disabled Adult Children of any age*** <br> *Must be disabled and enrolled prior to age 26. | |
|---|---|
| **Required Enrollment Forms** | **Acceptable Document(s) to Verify Eligibility** |
| Health: <br> ☐ Health Benefit Plan Enrolment Form (HBD-12) <br> Dental: <br> ☐ Dental Plan Enrollment Authorization (STD. 692) <br> Vision: <br> ☐ Premier Vision Plan Enrollment Authorization (CalHR 774) <br> ***AND*** <br> ☐ Member Questionnaire for Disabled Dependent (HBD-98) <br> ☐ Medical Report for Disabled Dependent (HBD-34) | Follow certification process for disabled dependents in accordance with CalPERS Circular Letter #600-045-12. |

SAMPLE

| **Children up to age 26 for whom the employee assumes a Parent-Child Relationship (PCR)* in-lieu of the parent by assumption of parental status OR assumption of parental duties** <br> *Note: The departmental HR representative determines if a "parent-child relationship" exists as evidenced by the assumption of parental status or duties and upon review of documents provided by the employee substantiating their relationship with the dependent. | |
|---|---|
| **Required Enrollment Forms** | **Acceptable Document(s) to Verify Eligibility** |
| Health: <br> ☐ Health Benefit Plan Enrollment Form (HBD-12) <br> ☐ Declaration of Health Coverage (HBD-12A) <br> ☐ Affidavit of Parent-Child Relationship (HBD-40) <br> Dental: <br> ☐ Dental Plan Enrollment Authorization (STD. 692) <br> ☐ Dental Affidavit of Eligibility (CalHR 025) <br> Vision: <br> ☐ Premier Vision Plan Enrollment Authorization (CalHR 774) | For PCR dependent(s) under age 19: Document that demonstrates employee has assumed a parent-child relationship in-lieu of the parent, such as: <br> ☐ Copy of front page of most recent federal or state income tax return; or, <br> ☐ Court order naming employee as child's legal guardian; or, <br> ☐ Document that substantiates the child's financial dependence upon employee such as bank, credit card, tuition or insurance statement(s) or payments, school records, indicating child resides at employee's current address; or, <br> ☐ Bills or mail indicating common residency with the dependent (collectively referred to as "Other Suitable PCR Documentation") <br> <br> For PCR dependent(s) from age 19 up to age 26: Document that demonstrates employee has assumed a parent-child relationship in-lieu of the parent, such as: <br> ☐ Copy of front page of most recent federal or state income tax return; or, <br> ☐ Other suitable PCR Documentation, as mentioned above, that substantiates the child's financial dependence upon employee provided that the child: either, <br> ☐ lives with employee for more than 50 percent of the time, or is a full-time student and <br> ☐ is dependent upon employee for more than 50 percent of the child's support. |

CalHR 781 Page 2 of 4 (rev 06/2016)

# Dependent Eligibility Verification Checklist (CalHR 781) *Continue*

## Sample of CalHR 781 – page 3 & 4

**Recertification of Parent-Child Relationship (PCR)**

**Note:** Employee must submit a signed and dated Affidavit of Parent-Child Relationship and supporting documentation annually to demonstrate a current parent-child relationship with enrolled dependent(s).

| Required Enrollment Forms | Acceptable Document(s) to Verify Eligibility |
|---|---|
| Health:<br>☐ Affidavit of Parent-Child Relationship (HBD-40) for each dependent<br><br>Dental:<br>☐ Dental Plan Enrollment Authorization (STD. 692)<br>☐ Dental Affidavit of Eligibility (CalHR 025)<br><br>Vision:<br>☐ Premier Vision Plan Enrollment Authorization (CalHR 774) | For PCR dependent(s) under age 19: Document that demonstrates employee has assumed a parent-child relationship in-lieu of the parent, such as:<br>☐ Copy of front page of most recent federal or state income tax return; or,<br>☐ Court order [illegible] child's legal guardian; or,<br>☐ Document that substantiates the child's financial dependence upon employee such as bank, credit card, tuition or insurance statement(s) or payments, school records, indicating child resides at employee's current address; or,<br>☐ Bills or mail indicating common residency with the dependent (collectively referred to as "Other Suitable PCR Documentation")<br><br>For PCR dependent(s) from age 19 up to age 26: Document that demonstrates employee has assumed a parent-child relationship in-lieu of the parent, such as:<br>☐ Copy of front page of most recent federal or state tax return; or,<br>☐ Other suitable PCR Documentation, as mentioned above, that substantiates the child's financial dependence upon employee provided that the child: either,<br>☐ lives with employee for more than 50 percent of the time, or is a full-time student and:<br>☐ is dependent upon employee for more than 50 percent of the child's support. |

SAMPLE

**Section 2. Acknowledgement of Employee Obligations**

**To be completed by employee (must initial all):**

I hereby certify under penalty of per

_____ I understand the eligibilit me is true and correct to

_____ I provided the required d

_____ I understand that additio necessary, to substantia

_____ I agree to notify my dep marriage or domestic pa dependent(s) eligibility o

_____ I understand that making representation or knowir false information with the termination of employme

_____ I agree that I may be rec the CalPERS system for expenses, and attorney' is found to be inaccurate

_____

Employee Signature
CalHR 781

**Section 3. Certification by Human Resources Staff**

**To be completed by Department/Agency (must initial all):**

I hereby certify under penalty of perjury that:

_____ I am a duly appointed and qualified representative of the agency/department named below.

_____ I have reviewed employee's health, dental, and/or vision enrollment form(s) and supporting documents to verify their dependent(s) eligibility.

_____ I informed employee that they are required to notify their employer in writing, within 60 days, upon the dissolution of a marriage or domestic partnership, when a parent-child relationship ceases, or a change in dependent(s) eligibility occurs.

_____ I informed employee that they may be required to reimburse their employer, the health, dental, or vision benefit plan, and the CalPERS system for expenditures made for medical claims, processing fees, administrative expenses, and attorney's fees on behalf of any family member, if any of the submitted documentation is found to be inaccurate or fraudulent and that a review of eligibility can occur at any time.

_____ I retained copies of the employee's health, dental, and/or vision enrollment form(s) and all supporting documents to verify eligibility of employee dependent(s) in the employee's Official Personnel File.

_____ I will provide a copy of this completed and signed Checklist to the employee.

_____ Based on the information provided and review of the documentation, I am approving the enrollment of such dependent(s).

HR Representative Name/Title _____ HR Representative Signature _____ Date _____

**PRIVACY NOTICE**

This notice is provided pursuant to the Information Practices Act of 1977.

The California Department of Human Resources (CalHR), Benefits Administrators are requesting the information specified on this form pursuant to Government Code Sections 1151, 1153, Section 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.

The information collected will be used for administering Health, Dental, and Vision Program benefits and will be disclosed to the administrators.

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to providethe information requested, CalHR will not be able to process this document.

**Department Privacy Policy**
The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy on CalHR's website (calhr.ca.gov).

**Access to Your Information**
Information provided on this form will be maintained in confidential files of CalHR for five years. Individuals have the right of access to copies of this form on request. Send requests to:

CalHR Privacy Officer
1515 S Street, North Building, Suite 500
Sacramento, California 95811-7258
916-324-0455
CalHRPrivacy@calhr.ca.gov

CalHR 781 Page 4 of 4 (rev 06/2016)

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# Probationary Periods/Performance Appraisals

This Manual Section

- Explains the probationary periods/performance appraisal process
- Identifies the objectives of the annual performance appraisal and Individual Development Plan (IDP)

This section contains the following topics:


| Topic | See Page |
|---|---|
| Probation Period | 110 |
| Policy | 110 |
| Required Hours | 110 |
| Definition | 110 |
| Responsibilities | 110 |
| Performance Appraisal | 111 |
| Policy | 111 |
| Submission | 111 |
| ABMS Alert | 112 |

# Probationary Periods/Performance Appraisals *Continue*

### Probationary Periods

A probationary period is a period of specified time (usually 6 or 12 months) at the beginning of an appointment that is used for a close review of an employee's performance prior to granting the employee permanent status. This is the final step in the selection process.

### Policy

It is the policy of DGS to evaluate the work and efficiency of a probationer at frequent intervals to keep the employee adequately informed of progress on the job. If the employee is rejected during the probationary period, a final report may be filed for the period not covered by previous reports.

### Required Hours

During the probationary period, the employee is required to work the following hours:

- 840 hours if serving a six-month probationary period
- 1,260 hours if serving a nine-month probationary period
- 1,680 hours if serving a twelve-month probationary period

In the event a probationer has not, during the length of the probationary period, worked the required number of hours, probation will automatically be extended until the probationer has worked the required number of hours. The State Personnel Board (SPB) and the probationer shall be notified of an extension, in writing.

### Definition

A probationary report (Report of Performance for Probationary Employees - STD 636) helps the supervisor and employee:

- Adapt to his/her job and work environment
- Recognize effective performance
- Identify aspects of performance that could be improved
- Be used as a tool for guidance in training grant permanent civil service status

### Responsibilities

| | |
|---|---|
| Attendance Clerk (AC) | • Determines probationary due dates using the Notice of Personnel Action (NOPA) and 'alert' generated by ABMS<br>• Tracks hours for permanent intermittent (PI) employees<br>• Notifies supervisor one month prior to due date |
| Supervisor | • Receives ABMS alert for probationary report and annual performance appraisal<br>• Completes the STD 636 meets privately with employee to discuss report<br>• Obtains appropriate signatures<br>• Distributes copies<br>• Submit the form and any supporting documentation to OHR for filing |

# Probationary Periods/Performance Appraisals *Continue*

### Performance Appraisals

The appraisal of work performance provides recognition for effective performance and identifies aspects of performance which could be improved. Performance appraisal is a continuing responsibility of all supervisors and supervisors should discuss performance informally with each employee as often as necessary to ensure effective performance throughout the year. Following the end of the employee's probationary period, the supervisor must make an appraisal in writing and shall discuss with the employee overall work performance at least once in each twelve calendar months.

Appraising the performance of employees is an important and continuous responsibility of supervisors at every level. Supervisors should ensure that each employee understands the requirements of the job and the performance expectations that are used to measure success or failure in the job.

### DGS policy

It is the policy of the DGS to evaluate the work and efficiency of a permanent employee (individual who has successfully passed his/her probationary period) at sufficiently frequent intervals to keep the employee adequately informed of progress on the job; generally, at least once in every twelve calendar months following the end of the employee's probationary period.

Performance appraisal shall be governed by the following:

- The appraisal of work performance provides recognition for effective performance and identifies aspects of performance that could be improved
- Performance appraisal is a continuing responsibility of all supervisors, and supervisors shall discuss performance informally with each employee as often as necessary to ensure effective performance throughout the year
- Each supervisor, as designated by DGS, shall make an appraisal in writing and shall discuss with the employee overall work performance at least once in each twelve calendar months following the end of the employee's probationary period for the purpose of informing the employee of (Individual Development Plan (IDP):

    - The caliber of the employee's work
    - Helping the employee recognize areas where performance could be improved
    - Developing with the employee a plan for accomplishing such improvement

- Each employee shall be given a copy of the written appraisal covering the employee's own performance and is privileged to discuss it with DGS management before it is filed.

### Submission

Once the form has been completed and signed by employee and supervisor, submit the form and any supporting documentation to OHR for filing. The employee retains a copy.

# Probationary Periods/Performance Appraisals *Continue*

### ABMS IDP Alert

DGS Supervisors receive Activity Based Management System (ABMS) emails notifying them of their employee's IDP due dates and a link to the STD. 637 form. (All employees should receive an IDP annually after completing their probationary period.)

### Example of ABMS IDP Alert

```
-----Original Message-----
From: ABMS R12 Production [mailto:NoReplyTo@dgs.ca.gov]
Sent: Wednesday, July 13, 2011 1:30 AM
To: Tiger Woods@dgs.ca.gov
Cc: Mickelson, Phil@DGS; Palmer, Arnold@DGS
Subject: Individual Development Plan (Std. 637)


Hello Tiger Woods:

In accordance with DGS Office of Human Resources (OHR) Personnel
Operations Manual, the following employees are due for an Individual
Development Plan (Std. 637) in August  2011.

JOHN DALY

This alert retrieves all Permanent Employees (except CBID 99) not
currently serving a probationary period.  Performance Appraisals are not
required for employees who completed a probationary period within six
months prior to their birth date and their job performance is standard or
higher.  For more information, please refer to the Personnel Operations
Manual (POM) on OHR's website at POM – IDP .

Once you and your employee have discussed and signed the IDP, please
follow your Division/Office instructions for forwarding the completed
Std. 637 to OHR.

Please do not reply to this alert as it was sent through an unattended
mailbox.  Contact your office Attendance Clerk or the Training and
Performance Enhancement Section for assistance, if needed.

For a template of the IDP (Std. 637) form, please click on this link.
DGS STD 637
```

# Probationary Periods/Performance Appraisals *Continue*

**Example of STD 636**
**Form is available at:** www.osp.dgs.ca.gov.

STATE OF CALIFORNIA – DEPARTMENT OF HUMAN RESOURCES

REPORT OF PERFORMANCE FOR PROBATIONARY EMPLOYEE

STD. 636 (REV. 12/2015) (Page 1 of 3)

Save | Clear | Print

☐ FIRST
☐ SECOND
☐ THIRD

READ INSTRUCTIONS ON BACK BEFORE COMPLETING THIS FORM

| NAME (Last) | (First) | (MI) | SOCIAL SECURITY NUMBER (LAST 4 DIGITS) | REPORT DATE |
|---|---|---|---|---|
| CIVIL SERVICE TITLE | | | POSITION NUMBER | DATE PROBATION ENDS |
| DEPARTMENT NAME | | | DIVISION / UNIT | EMPLOYEE'S HEADQUARTERS |

SAMPLE

YOUR WORK PERFORMANCE WILL DETERMINE WHETHER YOU OBTAIN PERMANENT CIVIL SERVICE STATUS

| QUALIFICATION FACTORS | RATINGS ARE INDICATED BY "X" MARKS | | | |
|---|---|---|---|---|
| | UNACCEPTABLE | IMPROVEMENT NEEDED | STANDARD | OUTSTANDING |
| 1. **SKILL**–Expertise in doing specific tasks; accuracy; precision, completeness, neatness, quantity. | | | | |
| 2. **KNOWLEDGE**–Extent of knowledge of methods, materials, tools, equipment, technical expressions and other fundamental subject matter. | | | | |
| 3. **WORK HABITS**–Organization of work; care of equipment; punctuality and dependability; industry; follows good practices of vehicle and personal safety. | | | | |
| 4. **RELATIONSHIPS WITH PEOPLE**–Ability to get along with others; effectiveness in dealing with the public, other employees, patients or inmates. | | | | |
| 5. **LEARNING ABILITY**–Speed and thoroughness in learning procedures, laws, rules and other details; alertness; perseverance. | | | | |
| 6. **ATTITUDE**–Enthusiasm for the work; willingness to conform to job requirements and to accept suggestions for work improvement; adaptability. | | | | |
| 7. **COMMUNICATION**–Exhibits aptitude toward good writing and verbal skills, can give concise information in working situations. | | | | |
| 8. **ABILITY AS SUPERVISOR**–Proficiency in training employees and planning, organizing, assigning and expediting work; leadership; understanding of and effectiveness in implementing departmental and State Personnel Board (SPB) personnel management policies including equal employment opportunity and affirmative action. | | | | |
| 9. **ADMINISTRATIVE ABILITY**–Promptness of action; soundness of decision, application of good management practices; understanding and effective implementation of departmental and SPB personnel management policies related to equal employment opportunity and affirmative action. | | | | |
| 10. **FACTORS NOT LISTED ABOVE** (Use additional sheets if more space is needed.) | | | | |
| **OVERALL RATING**–The overall rating must be consistent with the factor ratings and comments, but there is no prescribed formula for computing the overall rating. | | | | |

**COMMENTS TO EMPLOYEE**–(Supervisor should include factual examples of exceptional or poor work and give suggestions as to how performance can be improved. Factor and overall ratings of unacceptable and overall ratings of outstanding must be substantiated. Use additional sheets if more space is needed).

Rater discussed report with employee ☐ YES ☐ NO

I RECOMMEND YOU BE GRANTED PERMANENT CIVIL SERVICE STATUS
(To be checked only on Final Report. If the probationer is rejected, notification must be given as prescribed by Government Code Section 19173.) ☐ YES ☐ NO

| RATER'S SIGNATURE | TITLE | DATE SIGNED |
|---|---|---|

*In signing this report, I do not necessarily agree with the conclusions of the rater.*

| EMPLOYEE'S SIGNATURE | DATE SIGNED | ☐ I would like to discuss this report with the reviewing officer. |
|---|---|---|

*I concur in the ratings given by the rater. I have made no change in this report.*

| REVIEWING OFFICER'S SIGNATURE | DATE SIGNED | As requested, reviewing officer discussed report with employee on: DATE |
|---|---|---|

**DISTRIBUTION COPIES: 1 - Departmental Files 2 - Employee 3 - Supervisor 4 - Miscellaneous**

# Probationary Periods/Performance Appraisals *Continue*

**Sample of the Individual Development Plan (STD 637) (Front)**

**Form is available at:** www.osp.dgs.ca.gov.

Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF PERSONNEL ADMINISTRATION

**INDIVIDUAL DEVELOPMENT PLAN**

FOR FUTURE JOB PERFORMANCE OF PERMANENT EMPLOYEES

STD. 637 (REV. 7-94c)

| | | |
|---|---|---|
| EMPLOYEE NAME *(Last, First, Middle Initial)* | DATE OF THIS PERFORMANCE DISCUSSION | |
| CIVIL SERVICE TITLE | POSITION NUMBER | LAST PERFORMANCE DISCUSSION DATE |
| STATE DEPARTMENT NAME | DEPARTMENT SUBDIVISION | EMPLOYEE'S HEADQUARTERS |

| | |
|---|---|
| **PERFORMANCE OBJECTIVES** — Goals for further improvements in job performance during the next year in order to meet or exceed standards for the employee's present job or to develop employee skills. | **PLANS FOR ACHIEVING OBJECTIVES** — Specific methods by which the employee can work toward accomplishing his or her performance objectives (in-service training courses, college courses, rotation, special work assignments for training purposes, etc.). |

SAMPLE

***I HAVE PARTICIPATED IN A DISCUSSION OF OVER-ALL JOB PERFORMANCE***

| | | | |
|---|---|---|---|
| EMPLOYEE'S SIGNATURE | DATE SIGNED | SUPERVISOR'S SIGNATURE | DATE SIGNED |

***(Over)***

# Probationary Periods/Performance Appraisals *Continue*

## Sample of the Individual Development Plan (STD 637) (Back)

STATE OF CALIFORNIA — DEPARTMENT OF PERSONNEL ADMINISTRATION

**PERFORMANCE APPRAISAL SUMMARY**

OF PAST JOB PERFORMANCE OF PERMANENT EMPLOYEES

STD. 637 (REV. 7-94c) (REVERSE)

SAMPLE

| PERFORMANCE FACTORS | I | M | E* | COMMENTS* |
|---|---|---|---|---|
| 1. **QUALITY OF WORK:** Consider the extent to which completed work is accurate, neat, well-organized, thorough, and effective. | | | | |
| 2. **QUANTITY OF WORK:** Consider the extent to which the amount of work produced compares to quality standards for length. | | | | |
| 3. **WORK HABITS:** Consider the employee's effectiveness in organizing and using work tools and time, in caring for equipment and materials, in following good practices of vehicle and personal safety, etc. | | | | |
| 4. **RELATIONSHIPS WITH PEOPLE:** Consider the extent to which the employee recognizes the needs and desires of other people, treats others with respect and courtesy, and inspires their respect and confidence, etc. | | | | |
| 5. **TAKING ACTION INDEPENDENTLY:** Consider the extent to which the employee shows initiative in making work improvements, identifying and correcting errors, initiating work activities, etc. | | | | |
| 6. **MEETING WORK COMMITMENTS:** Consider the extent to which the employee completes work assignments, meets deadlines, follows established policies and procedures, etc. | | | | |
| 7. **ANALYZING SITUATIONS AND MATERIALS:** Consider the extent to which the employee applies consistently good judgment in analyzing work situations and materials, and in drawing sound conclusions. | | | | |
| 8. **SUPERVISING THE WORK OF OTHERS:** Consider the employee's effectiveness in planning and controlling work activities, motivating and developing subordinates, improving work methods and results, encouraging and supporting employee suggestions for work improvement, applying policies, selecting and developing subordinates in accordance with State Personnel Board and departmental affirmative action policies. | | | | |
| 9. **PERSONNEL MANAGEMENT PRACTICES:** Consider the extent to which the employee understands and applies good personnel management practices including affirmative action and upward mobility. Does the employee contribute effectively to the implementation of State Personnel Board and departmental equal employment opportunity policies and to the attainment of affirmative action goals? | | | | |

GENERAL COMMENTS OR COMMENTS ON OTHER FACTORS

*The supervisor may make "comments" only, or may use rating categories only, or may use either or both methods of appraisal on any performance factor, as he or she prefers. The rating categories are:

I - Improvement needed for performance to meet expected standards
M - Performance fully meets expected standards
E - Performance consistently exceeds expected standards

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# Compensation

This Manual Section

- Explains how an employee's payroll is processed
- Explains the process for preparation and releasing of payroll warrants
- Identifies the types of salary increases and adjustments available to employees within State service
- Holiday Pay

This chapter contains the following topics:


| Topic | See Page |
|---|---|
| Payroll Warrants | 118 |
| Preparation and Release of Payroll Warrants | 118 |
| Overtime | 119 |
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| Process of Approval | 123 |
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| Holiday Pay | 128 |
| Working on Holiday | 128 |
| PAL Holiday Entries | 130 |

# Payroll Warrants

The State payroll system was established with internal controls and processes to ensure compliance with the State Controller's Office guidelines and with State Administrative Manual regulations. Consequently, the preparation and distribution of payroll checks is a shared responsibility; with each department, unit and reporting unit supervisor performing an important function in the process of compensating the departmental employees. This section explains the responsibilities and departmental policies related to the release of regular and supplemental payroll warrants.

**Payroll warrant processing and release**

All payroll warrants for employees of the department are prepared by the State Controller's Office. Payments are based upon employee status and attendance information received from the department. Employees' attendance information is keyed into the Project Accounting and Leave (PAL) system. For those Agencies who do not have access to the PAL system a STD 634 is submitted to PTU for the attendance information.

**Types of payments**

Warrants are received by the Accounting Unit and distributed to the reporting units for the following types of payments:

- Monthly Salary Payments
- Supplemental or corrected monthly salary payments
- Overtime or excess hours payments
- Salary payments to separated employees, including lump sum vacation/overtime
- Salary advance checks
- Merit award checks
- Superior Achievement awards
- NDL, IDL, or State Compensation checks
- Miscellaneous pay, bonus, refund, or retroactive checks

# Overtime

Government Code Section 19851 states that it is the policy of the State that the workweek of the state employee shall be 40 hours, and the workday of state employees eight hours, except that workweeks and workdays of a different number of hours may be established in order to meet the varying needs of state agencies. It is the policy of the State to avoid the need for overtime work whenever possible. This policy does not restrict the extension of regular working hour schedules on an overtime basis in those activities and agencies where such is necessary to carry on the state business properly during a manpower shortage.

The California Department of Human Resources (CalHR) rules, Fair Labor Standards Act (FLSA) and the bargaining unit agreements require compensation for various types of overtime. The rules relating to the type of overtime are determined by the work week group definitions.

The CalHR laws and rules define “overtime” as authorized time worked in excess of the regularly scheduled work week. CalHR further defines “compensable” overtime as ordered overtime which is in addition to the regular work and which meets the standards for which cash compensation or compensating time off (CTO) is provided.

### Overtime Authorization

Overtime must be authorized in advance, except in an emergency, by the employee’s manager or supervisor. This authorization must also be confirmed in writing not later than ten (10) days after the end of the pay period during which the overtime was worked. The department (DGS) shall maintain complete and accurate records of all compensable overtime worked by its employees.

### Overtime Compensation

Overtime may be compensated on a cash or CTO basis at the discretion of the department (DGS) head or designee. Both parties agree and understand that a different type of overtime payment (cash or CTO) may be provided to employees at different times and may even be different for employees in the same or similar situations. However, in the event that the Department of Industrial Relations determines that this provision is inconsistent with Labor Code section 204.3, the parties agree to immediately meet and confer regarding the impact of that determination.

# Overtime *Continue*

**Compensation Time Off (CTO)**

CTO for employees shall be earned on a time and one-half (1½) basis and may be authorized in lieu of cash compensation. If an employee is not allowed CTO within twelve (12) pay periods following the pay period in which the overtime was worked, payment shall be made for such overtime on the next payroll.

When the employee wishes to use the overtime on a CTO basis, a request is given to the supervisor. The supervisor will approve or disapprove the request using the same standards as for any request for time off within the unit.

**Overtime payment types**

- Premium Pay

Overtime hours worked in excess of 40 hours in the work week will be paid at time and one-half.

- Straight Pay

Overtime hours worked not in excess of 40 hours in a work week will be paid at the straight time rate.

***Important!*** Per PML 2009-014, Change in Overtime: For the purpose of computing the number of hours worked, time when an employee is excused from work because of holidays, sick leave, vacation, annual leave, compensating time off, or any other leave shall not be considered as time worked by the employee for the purpose of computing cash or compensating time off for overtime. Overtime hours worked within this work week will be paid at straight time. See PML via CalHR's website link below:
PML 2009-014

# Overtime *Continue*

### Work Week Group

A Work Week Group (WWG) defines the employees' work week and overtime pay by classification.

The chart below identifies the Work Week Group (WWG) definitions established under the Fair Labor Standards Act (FLSA).

| WWG | Hours Worked | Work Period | Compensation |
|---|---|---|---|
| 2 | Under the provisions of the FLSA, only the time spent which is controlled or required by the State and pursued for the benefit of the State need be counted. | Defined as a fixed and regularly occurring period of 168 hours - seven consecutive 24-hour periods. | The method of compensation, cash or CTO, for FLSA overtime worked shall be at the discretion of the appointing power, pursuant to MOU provisions. |
| E | Employees are paid on a "salaried" basis and the regular rate of pay is full compensation for all hours worked to perform assigned duties. | Shall not be required to document hours worked for payroll purposes. | Shall not receive any form of additional compensation, whether formal or informal, unless otherwise provided by the provisions of this WWG. |
| SE | Work Week Group "SE" applies to classes and positions with an average work week of 40 hours. | Hours of work in excess of the average work week are not compensable, and shall not be deemed overtime. | The regular rate of pay is full compensation for all time that is required for the employee to perform the duties of the position. |

### Travel time

The travel time of employees who are covered by FLSA shall only be considered as time worked if it meets the definitions and requirements of travel time in sections 785.34 through 785.41 of Title 29 of the Code of Federal Regulations. See link below:

Code of Federal Regulations

# Salary Increases and Adjustments

This Manual Section

- Defines the types of salary adjustments and alternate salary range available to employees within State service
- Defines the conditions that have to be met for movement in a salary range
- Explains the notification process when an employee is due to receive a salary adjustment

Salary adjustments, both special in-grade (SISA) and merit (MSA) are based on the appointing authority's (DGS) certification that the skill and productivity of most employees have increased significantly after a period of time on any job. Periodic salary increases are intended to provide both an incentive for employees below the maximum of their salary range to achieve this normal growth and recognition of such growth as it is achieved. It is not necessary that an employee's performance be exceptional for him/her to receive a salary adjustment. However, a salary adjustment should not be recommended when an employee's job does not meet the normal growth expected by the department of employees with equal experience in the same kind job.

**Special In-Grade Salary Adjustment** (SISA)

A Special In Grade Salary Adjustment (SISA) is a salary increase from the first step to the second step in the range given at the completion of six qualifying pay periods or at the completion of 960 hours for intermittent employees.

This increase, given at the discretion of the department, may be granted only to SISA classes. SISA classes are identified on the Civil Service Pay Scales and may be accessed via California Department of Human Resources (CalHR) website link: http://www.calhr.ca.gov/Pages/home.aspx

All SISAs are effective on the first of the monthly pay period.

# Salary Increases and Adjustments *Continue*

**Merit Salary Adjustment** (MSA)

Merit salary adjustment (MSA) is an annual increase equivalent to up to one step (5%) in the salary range (not to exceed the maximum salary of the class) to which the employee is entitled if he/she meets the following conditions:

The appointing authority (DGS) certifies that the employee

(1) has met the standards of efficiency required for the position
(2) is not paid at the maximum range of their salary
(3) has twelve (12) months of qualifying service or completion of 1,920 hours (for intermittent employees) after their:

- Appointment; or
- Last merit salary adjustment; or
- Last special in-grade salary adjustment (SISA); or
- Movement between classes which resulted in a salary increase of one or more steps

**ABMS Email Alert**

Supervisors and Attendance Clerks receive an Activity Based Management System (ABMS) email alert stating a MSA or SISA review is due for their employee. It is important to ensure the Project Accounting and Leave (PAL) reflects the correct supervisor or the alerts could be misdirected. These alerts generate approximately two months before an employee's anniversary date and have a Supervisor Certification of Salary Adjustment (DGS OHR 609) form attached for convenience.

**MSA Approval**

MSA approvals require a Supervisor Certification of Salary Adjustment form (DGS OHR 609) indicating the employee has met the quality and quantity of experience the position requires. The AC will return the approved DGS OHR 609 form to the Office of Human Resources (OHR) Personnel Specialist (PS) by the end of the month preceding the salary increase effective date.

# Salary Increases and Adjustments *Continue*

**MSA Denial**

Pursuant to DPA Rule 599.684, when employees have not met the standards of efficiency required for the position, their supervisor **shall** deny the employee's MSA.

The Supervisor must:

1. Consult with their Office of Human Resources (OHR) Constructive Intervention Unit (CIU) regarding the denial and supporting documentation.
2. Notify the employee of the denial, in writing, **no less than ten days before the salary adjustment effective date.** The denial must include evidence to substantiate why the employee has not met the standards or has a poor work product. Attach the notification to the DGS OHR 609 and document the date the employee was notified.
3. Indicate the employee **does not** meet the level of quality and quantity expected for the position on the DGS OHR 609. Specify when the MSA will be reconsidered, if applicable. (No less than three months.)
4. Submit the DGS OHR 609 and substantiation to CIU for processing.
   If the employee's performance improves after the subsequent review, submit the DGS OHR 609 to the PS indicating approval.

**Extending MSAs**

Supervisors should consult their C & P analyst regarding extending a MSA effective date if an employee's inability to meet the standards of efficiency was due to a permanent or temporary separation. A copy of the memo notifying the employee and the reason for the extension must be submitted to the PS. **Note**: Employees on permanent or temporary disability shall have the time counted towards their MSAs and SISAs.

**Worker's Comp**

Employees on an approved Worker's Compensation claim for over a year continue to receive MSAs as though they were still working. MSA denials are only applicable for attendance or performance issues before or after an approved worker's compensation claim.

**Appeal**

Employees may appeal within ten days, after receiving the denial, by following their bargaining unit grievance procedure.

The employee may appeal to the CalHR

within fifteen days after having exhausted the departmental remedy, as outlined above.

***Note: Merit Salary Adjustments are system generated by SCO on the employee's anniversary date unless an employee is off pay status. MSA's will be manually keyed by the Personnel Specialists when the employee is back on pay status.***

# Salary Increases and Adjustments *Continue*

**Alternate salary range**

An alternate range is an additional range of pay established for a class that represents compensation for:

- Satisfactorily completing the duties appropriate for the class for the period of time noted in the criteria of the alternate range; or
- Possessing the education/experience/skills/competencies as defined under each alternate range criteria for each class.

A deep class is one in which an employee gains status in each range. The employee moves from one range to the next by meeting the experience requirements listed in the alternate range criteria for the classification. The employee does gain status in the alternate range as though each range were a separate classification

**Deep class alternate range changes**

A deep class alternate range change is a salary movement that is in lieu of promotion to a separate classification. Movement to the next range is based on criteria specifically outlined Section 13 of the California State Civil Service Pay Scales. (Contact your Personnel Analyst for specifics.) Generally, satisfactory performance at the lower (current) range for a set time period justifies movement to the next higher range.

**Qualifying pay period**

A qualifying pay period for a SISA or MSA is any pay period in which the employee is paid for 11 days or more. Intermittent employees must work 160 hours to have a qualifying pay period.

Unpaid absences for more than 11 days that run from the end of one qualifying pay period into another qualifying pay period shall disqualify the second pay period**.**

# Salary Increases and Adjustments *Continue*

**Example of ABMS MSA/SISA alert**

-----Original Message-----
From: ABMS R12 Production [mailto:NoReplyTo@dgs.ca.gov]
Sent: Monday, March 28, 2011 2:31 AM
To: Carter, Sean
Subject: MSA/SISA TO CARTER, SEAN

Hello SEAN CARTER

The following employee(s) are eligible for a MSA/SISA:

TODD SMITH MSA/SISA: 01-JUN-2011 Sup: REGGIE NOBLE

A copy of this alert was sent to the supervisor(s) with the website address to the Supervisor's Certification of Salary Adjustment (DGS OHR 609) template. Please assist the supervisors if they should have any question.

Please do not reply to this alert as it was sent through an unattended mailbox. If you have any questions, please direct them to your HR Personnel Specialist.

**Example of ABMS Range Change email alert**

-----Original Message-----
From: ABMS R12 Production [mailto:NoReplyTo@dgs.ca.gov]
Sent: Saturday, May 01, 2010 6:23 AM
To: Jordan, Michael J
Subject: Range Change To JORDAN, MICHAEL J

JORDAN, MICAEL J

The following employee(s) are eligible for a range change as indicated below:

BRETT FAVRE Range Change effective 07/31/2010
BARRY BONDS Range Change effective 07/01/2010

A copy of this alert was sent to the supervisor(s) with the website address to the Supervisor's Certification of Salary Adjustment (DGS OHR 609) template. Please assist the supervisors if they should have any question.

Please do not reply to this alert as it was sent through an unattended mailbox. If you have any questions, please direct them to your HR Personnel Specialist.

# Salary Increases and Adjustments *Continue*

**Sample of Supervisor Certification of Salary Adjustment Form (GS-609)**

**Form is available at: http://www.dgs.ca.gov/osp/Home.aspx**

CLEAR SAVE

STATE OF CALIFORNIA

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

## SUPERVISOR CERTIFICATION OF SALARY ADJUSTMENT

DGS OHR 609 (Rev. 8/14)

SAMPLE

**TYPE OF ADJUSTMENT**

- ☐ MERIT SALARY ADJUSTMENT (MSA)
- ☐ SPECIAL IN-GRADE SALARY ADJUSTMENT (SISA)
- ☐ RANGE CHANGE FROM ☐ TO RA ☐

**EFFECTIVE DATE**

| ABMS NUMBER | EMPLOYEE | CBID | POSITION NUMBER |
|---|---|---|---|
| | | | |

### EMPLOYEE'S PERFORMANCE RATING

☐ Meets the level of quality and quantity expected by the Agency at this stage of an employee's experience in the position. Therefore, I recommend that the employee be granted the salary adjustment indicated above.

☐ **DOES NOT** meet the level of quality and quantity expected by the Agency at this stage of an employee's experience in the position. Therefore, I recommend that the employee **NOT BE** granted the salary adjustment indicated above.

*NOTE: It is required that employees denied an MSA, SISA, or Range Change be notified in writing. Submit a copy of the written notification, along with this completed form GS 609 to Office of Human Resources.*

| *FOR INTERMITTENT EMPLOYEES ONLY:* Please enter date the employee met the criteria for the adjustment as described below: | DATE |
|---|---|
| • MSA - Date completed 1920 hours | |
| • SISA - Date completed 960 hours | |
| • RANGE CHANGE - Date employee met alternate range criteria | |

**COMMENTS**

### SUPERVISOR CERTIFICATION

| SUPERVISOR SIGNATURE | DATE |
|---|---|
| | |

# Holiday Pay

G.C. 19853(c) provides that all **excluded and represented** employees who work on a holiday are entitled to receive straight-time pay for actual hours worked and eight (8)* hours of holiday credit which is included as part of the employee's regular pay warrant.

**When the holiday falls on the employee's regular scheduled day to work, the holiday credit included in the employee's pay warrant is expended regardless of the hours worked.*

To clarify the interpretation above, the employee receives a full pay warrant including 8 hours for the holiday regardless of the employee's work schedule. If the employee is scheduled to work on the holiday, the hours in the pay warrant are then considered time worked (hour-for-hour).

**Holidays**

State employees are entitled to 11 State paid holidays each year. Please refer to the Official State Holiday Schedule posted on the OHR website:

http://www.dgs.ca.gov/ohr/Resources/Toolkits/TimekeepingToolkit.aspx

Holidays for rank and file employees are regulated by the employees' Collective Bargaining Agreement (CBA), while government code regulates holidays for excluded employees. Refer to the Bargaining Contracts for holiday compensation.
www.calhr.ca.gov

**Working on Holiday**

Holiday compensation is issued to employees for all hours worked on a holiday in accordance with his/her classification's assigned work week group or bargaining unit contract.
It is important to note that holiday compensation is a separate form of compensation and should not be misconstrued with overtime. The notable differences between the two compensations are shown below:

| Holiday Compensation | Overtime Compensation |
|---|---|
| • Holiday pay is compensated for time worked on the holiday.<br>• Subject to retirement withholdings. | • Overtime is compensated for time worked in excess of 40 **physical** hours in a work week.<br>• Not subject to retirement withholdings. |

# Holiday Pay *Continue*

**Working on Holiday Continued**

- **Work Week Group (WWG) 2 Employees**: When an employee is required to work on an observed holiday, the employee shall receive eight hours of holiday credit and one and one-half (1½) the hourly rate for all hours worked on the observed holiday (refer to the Holiday Pay Entries chart). The method of compensation is at the State's discretion and employees will be compensated in cash.

- **WWG 2 Employees (Part-time)**: Part-time employees who are required to work on an observed holiday shall be entitled to compensation as follows: a pro-rated amount of holiday credit as specified in the chart below, and one and one-half (1-1/2) compensation for all hours worked on the observed holiday. Employees will be compensated in cash.

**CHART FOR COMPUTING HOLIDAY CREDITS FOR FRACTIONAL TIME BASE EMPLOYEES**

| TIME BASE | HOLIDAY CREDIT EARNINGS | TIME BASE | HOLIDAY CREDIT EARNINGS |
|---|---|---|---|
| 9/10 | 7.2 | 3/8 | 3.0 |
| 7/10 | 5.6 | 1/4 | 2.0 |
| 3/10 | 2.4 | 1/8 | 1.0 |
| 1/10 | 0.8 | 4/5 | 6.4 |
| 7/8 | 7.0 | 3/5 | 4.8 |
| 3/4 | 6.0 | 2/5 | 3.2 |
| 5/8 | 5.0 | 1/5 | 1.6 |
| 1/2 | 4.0 | | |

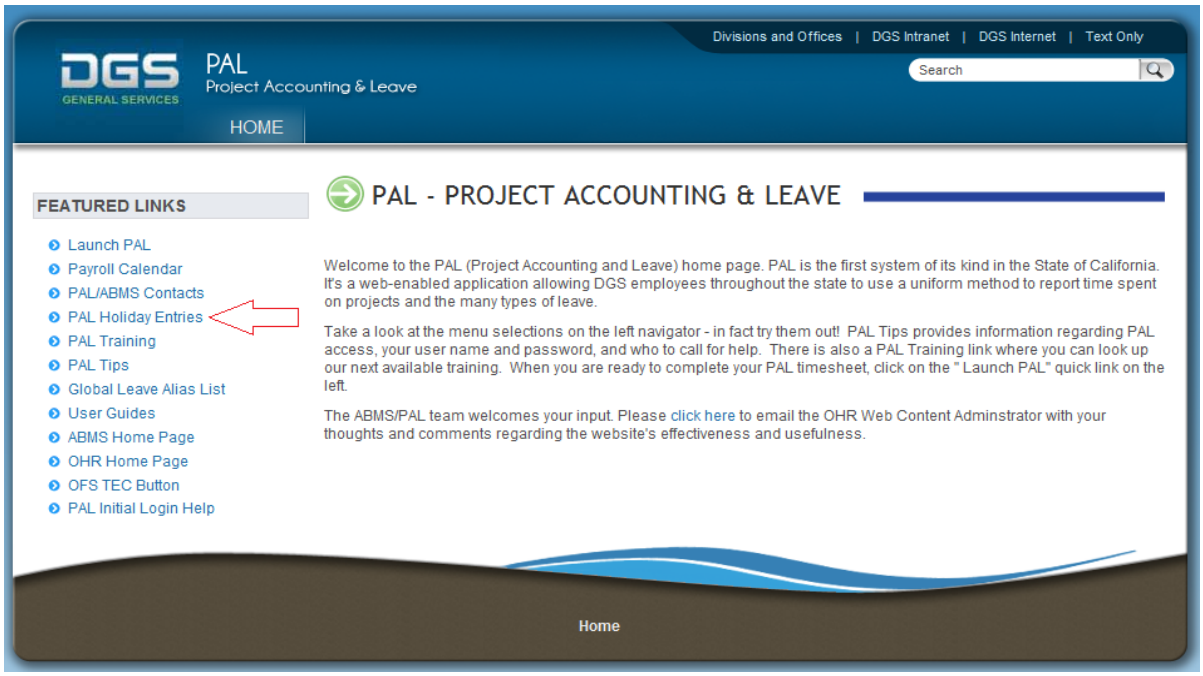
- Employees that are required to work overtime on a holiday are paid for all hours worked in excess of forty (40) straight time hours in the work week, in addition to any premium rate described above.

# Holiday Pay *Continue*

### PAL Holiday Entries

Please refer to the PAL website for the new Holiday Pay Entries chart which defines the proper method of posting holiday time worked in PAL. Employees must post time accordingly in order to be compensated timely for the holiday.

http://inside.dgs.ca.gov/pal/Home.aspx




### Holiday Pay Report

Holiday Pay is not generated automatically through an interface to SCO. It is manually keyed by your OHR Personnel Transaction Specialist around the 8th working day of the following pay period. ALL holiday time worked must be approved on or before the 5th working day (3 days prior) to ensure timely payment of holiday compensation.

When requested by the PTU Specialist, the Holiday Pay report will retrieve all physical time worked on holidays for employees. The report retrieves the number of work hours posted to PAL on the holiday, and enters it on the report for the PTU Specialist to key.

If the PAL Holiday entries are posted correctly and approved timely, and the Holiday Pay is keyed by the PTU Specialist around the 8th working day as indicated above, employees can expect to receive their holiday pay in a separate warrant on approximately the 10th working day (2 days later) of the pay period.

Due to compensable differences between holiday pay and overtime, holiday pay is not reflected on the PAL timesheet. Hours worked on a holiday are extracted from PAL and manually keyed by your OHR PTU Specialist.

# Leave of Absence (LOA)/Leave Types

This Manual Section

- Defines the eligibility and reinstatement criteria for leave of absence
- Identifies the  leave benefit types with a brief description
- Describes the Attendance Clerk's responsibilities in processing an employee's LOA
- Identifies the documents that need to be completed to initiate a leave or a disability claim

This section contains the following topics:


| Topic | See Page |
|---|---|
| Unpaid Leave of Absence | 132 |
| Eligibility for Leave of Absence | 133 |
| Reinstatement from a Leave of Absence | 133 |
| Request for Leave of Absence DGS OHR 28 | 135 |
| Types of Leaves, Policies and Programs | 137 |
| Leave Types | 141 |
| Family Medical Leave Act (FMLA) | 145 |
| Catastrophic Leave (CAT) | 162 |
| State Disability Insurance (SDI) | 182 |
| Non-Industrial Disability Insurance (NDI) | 191 |
| Workers Compensation (WC) | 196 |

# Leave of Absence (LOA)/Leave Types *Continue*

A Leave of Absence (LOA) can be paid or unpaid leave that allows an employee to be off work for an extended period of time and return to his/her former position when the leave ends. The criteria for granting an unpaid LOA are stated in Department of Personnel Administration (DPA) Rule 599.781 and in the Memoranda of Understanding (MOU). Approval of the request for leave of absence by the DGS is discretionary. It is the policy of DGS to comply with the provisions of the MOU and applicable CalHR laws, rules and regulations.

***Note***: Pursuant to DPA Rule 599.781, "A leave of absence **shall not** be granted under this section to any employee who is accepting some other position in the State service; or who is leaving the State service to enter other employment except as hereto in provided; or who does not intend to nor can reasonably be expected to return to State service on or before the expiration of the leave."

### Unpaid Leave of Absence

A department head or designee may grant an unpaid leave of absence for a period not to exceed one year. The employee shall provide substantiation to support the employee's request for an unpaid leave of absence.

Except as otherwise provided in subsection (a) below, an unpaid leave of absence shall not be granted to any employee who accepts some other position in State employment; or who leaves State employment to enter other outside employment; or does not intend to, nor can reasonably be expected to, return to State employment on or before the expiration of the unpaid leave of absence. A leave, so granted, shall assure an employee the right to his/her former position upon termination of the leave. The term "former position" is defined in Government Code section 18522.

(a) An unpaid leave of absence may be granted for, but not limited to, the following reasons:

- Union activity
- For temporary incapacity due to illness or injury
- To be loaned to another governmental agency for performance of a specific assignment
- To seek or accept other employment during a layoff situation or otherwise lessen the impact of an impending layoff
- Education
- Research project
- Personal or family matters
- To run for public office

# Leave of Absence (LOA)/Leave Types *Continue*

**Unpaid Leave of Absence** Continue

(b) Extensions of an unpaid leave of absence may be requested by the employee and may be granted by the department head or designee.

(c) A leave of absence shall be terminated by the department head or designee:

- At the expiration of the leave; or
- Prior to the expiration date with written notice at least thirty (30) work days prior to the effective date of the revocation.

Most common leave of absences requested:

- Parental
- Adoption

**Eligibility for Leave of Absence**

To be eligible for a leave of absence, the employee must have permanent or exempt status with a minimum of six months state service.

A probationary employee may have regular leave of absence only if the probationer has completed six months in a class having a longer probationary period than six months; or if he/she was prevented from completing the probationary period because of entry into the military service.

**Reinstatement from a Leave of Absence**

When a leave of absence ends, an employee is guaranteed the right of return to his/her former position. “Former position” means either:

- the last position which an employee held as a probationer, a permanent employee, or career, executive

or

- a position to which the Department could have assigned an employee within a designated geographical, organizational, or functional subdivision, as determined appropriate

Labor contracts provisions may vary regarding leave of absence. Refer to the appropriate bargaining unit agreement for specific eligibility provisions. Questions regarding the labor contracts may be directed to the Labor Relations Office.

# Leave of Absence (LOA)/Leave Types *Continue*

**Parental Leave**

A female employee unable to perform an essential function of her job due to pregnancy, childbirth, or a related medical condition may receive up to four months unpaid leave, as medically needed, under the Family Medical Leave Act. When the pregnancy disability leave ends, the employee may request up to 12 additional weeks of unpaid leave for bonding with her new child, under the California Family Rights Act (CFRA).

Note: The State will continue the employee's health benefits for the first 12 weeks of this combined leave.

A male spouse or male parent or domestic partner (as defined in accordance with Family Code section 297), who is a permanent employee, shall be entitled, upon request, to an unpaid leave of absence for a period not to exceed one year to care for his/her newborn child. The employee shall provide medical substantiation to support his/her request for parental leave.

***Note:*** The request must include the beginning and ending dates of the leave and must be requested no later than thirty (30) calendar days after the birth of the child. Any changes to the leave, once approved, are permissive and subject to the approval of the department head or designee.

Important: During the period of time an employee is on parental leave, he/she shall be allowed to continue their health, dental, and vision benefits. The cost of these benefits shall be paid by the employee and the rate that the employee will pay will be the group rate.

**Adoption**

A department head or designee shall grant a permanent employee's request for an unpaid leave of absence for the adoption of a child for a period not to exceed one (1) year. The employee may be required to provide substantiation to support the employee's request for adoption leave.

(a) During the period of time an employee is on adoption leave, he/she shall be allowed to continue their health, dental, and vision benefits. The cost of these benefits shall be paid by the employee and the rate that the employee will pay will be the group rate.

(b) Existing leave credits may be used for the purpose of assuming custody of the adopted child.

# Leave of Absence (LOA)/Leave Types *Continue*

**Request for Leave of Absence GS 28**

The form Request for Formal Leave of Absence, DGS OHR 28 is to be used to request the Formal Leave of Absence. All requests for a Leave of Absence (LOA) shall be granted or denied by the employee's supervisor and Office Chief or client Agency Executive.

The original copy of the DGS OHR 28 shall be forwarded to the Personnel Transactions Unit (PTU) along with any direct payment documents to continue the employee's insurance benefits (health, dental, etc.). If the request is denied, a copy of the denial letter must also be submitted with the DGS OHR 28.

| | |
|---|---|
| **Employee** | **The responsibility of the employee is:**<br>• to initiate a request for leave by completing a "Formal Leave of Absence" request form, DGS OHR-28<br>• to provide a reason and a beginning and ending date of leave (**not to exceed one year**)<br>• to forward the DGS OHR-28 to his/her immediate supervisor (provide substantiation when required or requested)<br>• to request an extension when needed by completing a new DGS OHR-28 and following this same procedure<br>• to make arrangements with immediate supervisor regarding return date before the leave expires<br>• to request "direct pay" forms from the Attendance Clerk (AC) to continue medical benefits and make direct payment to insurance(s) carrier(s) |
| **Supervisor** | **The responsibility of the immediate supervisor is:**<br>• to refer to the applicable MOU for specific information on granting an unpaid LOA<br>• to recommend LOA be approved or denied (must state reason why LOA should be denied)<br>• if denied, to retain a copy of the DGS OHR-28 in the supervisor's employee working file<br>• to initiate RPA prior to the return of the employee |
| **Office Chief or Client Agency Executive** | **The responsibility of the Office Chief or Client Agency Executive is:**<br>• to approve or deny request (must state reason for denial in writing)<br>• to inform the employee of the status of the LOA<br>• to forward approved request to assigned Personnel Specialist (PS) in the Personnel Transactions Unit (PTU) and retain the goldenrod copy<br>• prior to the employee's return, to forward the RPA to the C&P Analyst |
| **Personnel Specialist (PS)** | **The responsibility of the PS is:**<br>• to document action to the employee's employment history<br>• to return approved copies of DGS OHR-28 to employee and Office/Client Agency (send original to the employee's Official Personnel Folder (OPF)<br>• to process appropriate direct payment insurance(s) |

# Leave of Absence (LOA)/Leave Types *Continue*

**Request for Leave of Absence DGS OHR 28** Continue

**Sample of [Formal Leave of Absence Request DGS OHR 28]**

CLEAR SAVE

STATE OF CALIFORNIA
**FORMAL LEAVE OF ABSENCE REQUEST**
DGS OHR 28 (Rev. 4/16)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

***See below for additional information and instructions.***

| EMPLOYEE NAME (LAST, FIRST MI) | SOCIAL SECURITY NUMBER (LAST 4) | CBID |
|---|---|---|
| OFFICE/CLIENT AGENCY | POSITION NUMBER | TIME BASE |

**TO BE COMPLETED BY EMPLOYEE**

REQUEST TYPE

☐ **Initial Request** ☐ **Extension**

I hereby request a formal leave of absence for the following:

☐ Substantiation Attached

PERIOD OF LEAVE OF ABSENCE: FROM: TO:

| *I am aware that I am responsible for the payment of full premiums for any insurance in which I am enrolled.* | EMPLOYEE'S SIGNATURE | DATE |
|---|---|---|

**TO BE COMPLETED BY IMMEDIATE SUPERVISOR**

I RECOMMEND THE REQUEST FOR LEAVE OF ABSENCE BE:

☐ **APPROVED**

☐ **DENIED Explain:**

| PRINT SUPERVISOR'S NAME | SUPERVISOR'S SIGNATURE | DATE |
|---|---|---|

**TO BE COMPLETED BY OFFICE CHIEF OR CLIENT AGENCY EXECUTIVE**

THE REQUEST FOR LEAVE OF ABSENCE IS:

☐ **APPROVED**

☐ **DENIED** *Explain:*

| PRINT SUPERVISOR'S NAME | SUPERVISOR'S SIGNATURE | DATE |
|---|---|---|

**PERSONNEL TRANSACTION UNIT USE ONLY**

| DATE PAR KEYED | COMPLETED BY | DATE |
|---|---|---|

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

## Types of Leaves, Policies and Programs

The following discuss the various types of leaves, polices and programs available to eligible employees.

| Leave Benefits, Policies, & Programs | Summary | Related Rule, Law, or Regulations | Bargaining Unit | Eligibility | Paid by |
|---|---|---|---|---|---|
| Adoption Leave | Any permanent employee may request and be granted a leave of absence without pay for the adoption of a child for a period not to exceed six months or one year as specified | GC 19991.6(c)(3) FMLA, CFRA | 1-21, Excluded, including Confidential | All permanent employees | Unpaid |
| Annual Leave Program | Eligible employees earn annual leave credits rather than sick leave and vacation credits and are eligible to receive enhanced Non-Industrial Insurance (50% of gross salary and option to supplement with leave credits to 75% or 100% of gross pay) | GC 19858.4; 19858.5-19858.7; 1984 9.10-.18; | 1, 5-10, 12-14, 16-20, Excluded, including Confidential | All employees who have accrued leave credits and have elected to participate | Employer paid |
| Bereavement Leave | State employees are allowed paid time off if a specified member of their family dies. See MOUs | GC 19859.3, 1984 9.10-.18 | 1-21, Excluded, including Confidential | All permanent State employees and some probationary employees. See your personnel office | Employer paid |
| Catastrophic Leave Program | Allows eligible employees to receive donations of annual leave, vacation, compensating time off, personal leave, and/or holiday credits from other eligible employees when the receiving employee faces financial hardship due to injury or the prolonged illness of the employee, or specified family members | CCR 599.925 | 1-21, Excluded, including Confidential. Unit 20 Special Schools - refer to your MOU | All permanent State employees except for seasonal employees | Donated leave credits |
| Continuing Education Leave | Employees in specified classes will be entitled to educational leave to obtain continuing education units. The leave time can be taken up to the amounts specified by the class per fiscal year, subject to the operational needs of the department | GC 21006 | 16, 19, 20 | All employees in designated units and must be in a specific class | Unpaid, unless MOU states otherwise |
| Dependent Care Leave | Employees may be granted an unpaid leave of absence for the purposes of providing personal medical care for the employee's ill or injured parent, spouse, child, stepparent, grandchild, grandparent, mother-in-law, father-in-law, daughter-in-law, son-in-law, or brother-in-law. The employer is not required to maintain health, dental, or vision benefits and the leave is not job protected. | GC 19991.1 | 20 | All employees in designated units | Unpaid |
| Domestic Violence Leave | Employees may take time off to seek medical attention for injuries caused by domestic violence, obtain psychological counseling related to the experience of domestic violence, obtain services from a domestic violence shelter, program, or rape crisis center, or to participate in safety planning to increase safety from future domestic violence | Labor Code Section 230.1 | All | All employees of employers with 25 or more employees | Employer paid |

# Leave of Absence (LOA)/Leave Types *Continue*

## Types of Leaves, Policies and Programs Continue

| Leave Benefits, Policies, & Programs | Summary | Related Rule, Law, or Regulations | Bargaining Unit | Eligibility | Paid by |
|---|---|---|---|---|---|
| Elections | Subject to collective bargaining, an employee who has been appointed as a member of a precinct board and who takes time off from state employment to serve as a member of the precinct board on election day shall receive payment of regular wages or salary for the election day | DPA 599.930, GC 19844.7 | 1, 9, 10, 11, 14, 15, 17, 20, 21 | All employees in designated units | Employer paid |
| Enhanced Industrial Disability Leave | An employee who loses the ability to work for more than 22 workdays on the 40-hour clock as the result of an injury incurred in the official performance of his/her duties may be eligible for a financial augmentation to the existing industrial disability leave benefits (IDL). The intent of the program is to maintain, as closely as possible, the disabled employee's monthly take home pay | DPA 599.799, GC 19871.2, 19849.10-.18;<br><br>LC 4800-4820 | 6-8, 10, 16, 19, 20, Excluded, including Confidential;<br><br>1,3,4,11,12,13, 15,17,18,21 | The department's appointing power has the final decision regarding employee's eligibility for EIDL | Employer paid |
| Family Activity Leave | Employees are permitted to use accumulated leave credits to attend family or school-related activities. Departments are encouraged to provide flexible schedule arrangements to accommodate employee needs | DPA 599.910 | CSE Master, 12, 13, 16, Excluded, including Confidential | All permanent State employees | Employer paid |
| Family Crisis Leave | Employees may use accumulated leave credits (including sick leave credits where appropriate) to attend to family crisis situations. Departments are encouraged to provide flexible schedule arrangements to accommodate employee needs | DPA 599.910 | CSE Master, 12, 13, 16, Excluded, including Confidential | All permanent State employees | Employer paid |
| Family Medical Leave Act | Entitles an eligible employee to take 12 weeks of paid or unpaid, job-protected leave each calendar year, regardless of how much FMLA has been taken during the past 12 months, to obtain care for their own serious health condition or to care for a seriously ill child, parent, or spouse. Health coverage at the State contribution rate is continued for the duration of the leave | GC 12945.1-.2; Federal FMLA 1993 | All units, Excluded, including Confidential | All State employees with 12 months of service and 1,250 hours in the previous 12 months | Unpaid |
| Family School Partnership Act | Allows an employee to take up to 40 hours per calendar year, not exceeding eight hours in any calendar moth of the year, to participate in activities at his/her child's school | LC 230.8 | All units, Excluded, including Confidential | All State employees | Unpaid |
| Holiday-in-Lieu | Full-time employees shall be eligible to receive a total of 112 hours of holiday-in-lieu credit each calendar year. Employees shall request and may receive approval to use the holiday-in-lieu in accordance with the annual leave and vacation scheduling provided in their agreement | GC 19853.1 | 5 | All employees in designated unit | Employer paid |
| Holiday Compensation | In lieu of a normal holiday schedule, Unit 8 employees receive 13 floating holidays, plus one personal holiday, with pay per calendar year.<br><br>Employees shall be eligible to receive a total of 104 hours (112 hours for BU 12 and 13) of holiday-in-lieu credit each calendar year. Employees request an may receive approval to use this credit in accordance with annual leave or vacation scheduling provisions | GC 19853.1 | 8<br><br>12, 13, 16 | All employees in designated unit who are full time<br><br>All employees in designated unit who are full time | Employer paid |

# Leave of Absence (LOA)/Leave Types *Continue*

## Types of Leaves, Polices and Programs Continue

| Leave Benefits, Policies, & Programs | Summary | Related Rule, Law, or Regulations | Bargaining Unit | Eligibility | Paid by |
|---|---|---|---|---|---|
| Industrial Disability Leave | Provided to employees who are Public Employee's Retirement System (CalPERS) and State Teachers Retirement System (STRS) members and become temporarily disable because of a work-related injury | GC 19869-19877.1, 19849.10-.18 | 9, 19, 20, 21, Excluded, including Confidential | All State Teachers' Retirement System and CalPERS members | Employer paid |
| Informal Leave | An informal leave of absence without pay may be granted for a period not to exceed 11 working days in a 22-day period | GC 19991.1-.2 | 1-4, 6-8, 10-21, Excluded, including Confidential | Employees who have permanent status | Unpaid |
| Jury Duty | Employees may be absent with pay for jury duty provided they remit the jury fee to their department | GC 19991.3 | All units, Excluded, including Confidential | All State employees | Employer paid |
| Mentoring Program | Eligible employees may receive up to 40 hours of mentoring leave per calendar year to participate in mentoring activities once they have used an equal amount of their personal time for these activities | Executive Order W-132-96 (4/96) | 1-3, 4, 7, 9-12, 16, 19, 21 | All employees in designated units | Employer paid |
| Military Leave | Employees are allowed only 30 days of paid time off for either short-term or long-term military leave. Short-term military leave may be up to 180 calendar days; long-term leave is considered six months to four years | GC 20990-21002; MVC 389-399.5 | All units, Excluded, including Confidential | All State employees | Unpaid |
| Non-Industrial Disability Leave (NDI) | A wage continuation program provided to employees who are unable to work due to an injury or illness that is not work related | GC 19878-19885, 19849.10-.18 | All units, Excluded, including Confidential | All employees who are CalPERS members and have at least six months of service | Employer paid |
| Parental Leave of Absence | An employee may be granted up to one year of unpaid leave for purposes of pregnancy, childbirth, or care for a newborn child | GC 19991.6, 21013 | All units, Excluded, including Confidential | All State employees | Unpaid |
| Personal Holiday | Once an employee has completed six months of employment, each full-time employee becomes eligible for a personal holiday each fiscal year | GC 19854 | All units, Excluded, including Confidential | Employees who have completed six months of employment | Employer paid |
| | Permanent employees of BU 8 shall accrue a personal holiday every calendar year. Nonpermanent employees in BU 8 shall accrue a personal holiday at the completion of every six qualifying pay periods, but may not accrue more than one personal holiday in ay 12 consecutive pay periods | GC 19854 | 8 | | Employer paid |
| Personal Leave Program | Personal leave shall be requested and used by the employee in the same manner as vacation or annual leave | GC 19996.3; CCR 599.937 | All units, Excluded, including Confidential | Employees who have available leave credits | Employer paid |
| Pregnancy Disability Leave (PDL) | Unpaid leave for a period of actual disability caused by pregnancy, childbirth, or related medical conditions. PDL is provided for a maximum of four months, as medically needed | CCR, Title 2, Division 4, Sec 7291.2 | All units, Excluded, including Confidential | All female State employees | Unpaid |

# Leave of Absence (LOA)/Leave Types *Continue*

## Types of Leaves, Policies and Programs Continue

| Leave Benefits, Policies, & Programs | Summary | Related Rule, Law, or Regulations | Bargaining Unit | Eligibility | Paid by |
|---|---|---|---|---|---|
| Sick Leave | Employees appointed to permanent, limited-term (LT), or temporary authorization appointment (TAU) positions are entitled to accrue sick leave credits. Employees can use up to six months to care for an ill or injured family member, or any person residing within the immediate household. Such absence shall be limited to six workdays per occurrence or, in extraordinary situations, to the time necessary for care until physician or other care can be arranged | GC 19859, 19861-19864, 19866, 19143, 19991.4 | 1-21, Excluded, including Confidential | All State employees who have balances | Employer paid |
| Transfer Leave Credits for Family Members | Employees are permitted to transfer eligible leave credits between family members to care for ill family members, to provide leave credits for a family member who has serious health condition, or for parental or adoption leaves | DPA 599.913 | CSEA Units 2,5,6,7,10,12,16,18,19, Excluded, including Confidential | All permanent State employees | |
| Temporary Leave of Absence | Temporary leave may be granted without pay to any employee for a period not to exceed 30 calendar days | DPA 599.781, GC 19991.1 | All units, Excluded, including Confidential | All State employees | Unpaid |
| Unpaid Leave of Absence | Employees may be granted an unpaid leave of absence for a period not to exceed one year for reasons including union activity, temporary incapacity due to illness, education, research project, or to be loaned to another governmental agency | DPA 599.781, GC 19991.1 | 1-4, 6-8, 10-21, Excluded, including Confidential | All State employees, Excluded, including Confidential employees must have one year of service | Unpaid |
| Vacation | All employees (other than those enrolled in Annual Leave) earn vacation credits based on years of State service | GC 19858.1, 19856, 19856.1, 19863, 19991.4, 19849.10-.18 | All units, Excluded, including Confidential | All State employees with six months of service | Employer paid |
| Veteran's Educational Leave | Eligible employees who served in the armed forces may, upon application, be granted an educational leave of absence without pay | GC 21006; MVC 981-981.7 | All units, Excluded, including Confidential | All State employees | Unpaid |

# Leave of Absence (LOA)/Leave Types *Continue*

**Leave Types**

California State employees are eligible for several types of time off, below is a list of the most common leave benefits:

- Bereavement
- Military
- Jury duty
- ATO
- Voluntary Personal Leave Program

For additional information, you may refer to your bargaining unit's contract for specifics if you're a rank-and-file employee. ***If the contract provisions vary from the summaries below, the contract language prevails.***

**Bereavement**

A permanent employee receives up to three eight-hour days (24 hours) of bereavement leave (per occurrence) upon the death of a person related by blood, marriage, or adoption, or of any person residing in the employee's immediate household at the time of death. Upon approval of the supervisor, if additional leave is necessary, an employee may use accrued/earned leave credits or take leave without pay. When bereavement leave is necessary, the employee must notify his or her supervisor as soon as possible.

Additional two days of leave shall be granted if the employee is required to travel over 400 miles one way from his/her home. At the option of the employee, these two additional days can be taken without pay or charged against accrued/earned leave credits.

For rank-and-file employees, contract provisions limit such leave for deaths of extended family members to 3 days per year. Bargaining Unit contracts may be accessed via the link below:

http://www.calhr.ca.gov

Post the time under the alias "BL", for bereavement leave, on your Project and Accounting Leave (PAL) timesheet

# Leave of Absence (LOA)/Leave Types *Continue*

**Military**

"Military leave" means the leave of absence status of a permanent employee or probationer who leaves a position to serve in the armed forces of the United States in time of national emergency or state military emergency and who has the right under statutes relating to reinstatement of persons after military service to return to his position.
Pursuant to GC section 19991.6, "During a state military emergency and subject to department rule, an appointing power may grant a leave of absence without pay to a permanent or probationary employee under his/her jurisdiction to:

(a) engage in civilian war work pursuant to mandatory order of the agency of the United States or of the state having authority to make that order
(b) assume active duty in the United States merchant marine
(c) assume other duty rather than active duty to fulfill a military obligation pursuant to mandatory order of the agency
(d) assume active full-duty for the American Red Cross; such a leave shall not exceed the period authorized in the order.

The length of your military leave is the period of active duty plus one day for travel going to and returning from such duty, unless your orders already provide for additional travel time. Refer to the following Memos for additional information:

HR Memo 06-013 Military Leave
HR Memo 07-036A Military Service-Unpaid Spousal Leave
HR Memo 08-014 FMLA Service Member Family Leave Amendment

**Jury Duty**
An employee can serve on a jury for any court. Employees who perform jury duty will receive their regular salaries.

An employee whose work schedule is other than Monday through Friday, 8 a.m. to 5 p.m. must temporarily be adjusted until the employee is released from jury duty. Supervisors must provide a day shift work situation if the employee is not on jury duty for the full day. Employees will not lose shift differentials while serving jury duty.

The employee will provide the following to the Attendance Clerk
- A copy of the notice to appear for jury duty
- Daily attendance slips from the Jury Commissioners' Office

If fees were received for other than mileage or meals, also submit:

- An "approved" copy of your PAL timesheet reflecting the time used for Jury Duty, and
- A personal check or money order for Jury Duty fees less travel or meal expenses

**Post the time served under the alias "J", for jury, on your Project and Accounting Leave (PAL) timesheet**

# Leave of Absence (LOA)/Leave Types *Continue*

**Jury Duty** Continue

The Attendance Clerk responsibilities:

- Upon receiving necessary documents and payment for Jury Duty, verify all documents are present.
- Do not accept a check containing the Court payment for Travel Expenses.
- Enter the payroll Agency and Unit Code on the employee's PAL Timesheet.
- Mail or deliver the package to the following address:
  Department of General Services
  Office of Fiscal Services
  Attention: Receivable Unit
  707 3rd Street 10th Floor
  West Sacramento, CA 95605

**Administrative Time Off (ATO)**

Administrative Time Off (ATO) may be granted on a case-by-case basis as approved by DGS Director or designee, deemed to be in the best interest of the State. It is the goal to make every effort to return the employee to the worksite either in their own division or an appropriate position in any other division.

Government Code (GC) Section 19991.10 provides that no paid leave of absence for state employees shall exceed five working days without prior approval from CalHR.

Program Supervisors and Managers may grant ATO for employees for the following reasons:

1. Employee is a Precinct Election Board Worker (GC §599.930)
2. Employee works or resides in a county where the Governor has declared a state of emergency (DPA Rule 599.785.5 authorizes up to five working days)
3. Employee is called into service by the Office of Emergency Services (OES) for a search and rescue operation, disaster mission, or other life-saving mission conducted within the State (GC §19844.5 authorizes up to 10 calendar days)
4. Employee's physical work environment is considered temporarily hazardous or is detrimental to work productivity (e.g., equipment failure, building evacuation, gas leak)

# Leave of Absence (LOA)/Leave Types *Continue*

**Administrative Time Off (ATO)** Continue

Employees granted ATO of any type must use the appropriate ATO global alias to report their time in the Project Accounting and Leave (PAL) system. Specific ATO PAL aliases are described below:

**ATO-ELECT**
Employee is a Precinct Election Board Worker

**ATO-GOV-EMERG**
Employee works or resides in county declared a State of Emergency

**ATO-OES**
Employee is called to service by the Office of Emergency Services

**ATO-SAFE**
Employee works in an area deemed to be an environmental hazard and/or detrimental to work activity.
Note: This is not the alias for workplace violence issues it is for situations where an employee places other employees at risk.

**ATO-OHR**
Constructive Intervention Unit has been consulted and has approved placing the employee off work due to sensitive and confidential personnel-related reasons

For questions regarding ATO or to request ATO-OHR for an employee, please contact any member of the Constructive Intervention Unit.

**Voluntary Personal Leave Program (VPLP)**

Eligible full time employees may voluntarily participate in the VPLP program. Employees shall continue to work their assigned work schedule and shall have a reduction in pay equal to 5% in exchange of 8 hours of leave to be credited to their VPLP balance.

- Part time employees shall be subject to the same conditions as stated above, on a prorated basis.
- Intermittent employees shall be prorated based upon the number of hours worked in the monthly pay period.
- Bargaining units 12 & 13 do not have the option to participate.

  - VPLP credits will be available to use on the 1st day of the following monthly pay period for each month in the VPLP program.
  - Employees cannot accrue more than 240 hours.
    - Applies to rank and file employees in bargaining units 1, 3, 4, 5, 10, 11, 14, 15, 17, 20, 21, and all excluded employees.
    - Excluded employees may participate in the VPLP for 1 or 2 days.
  - Employees over the 240 hours cap will be deleted from participating in the program.
  - Once balance is reduced to 120 hours or less and employee has not participated in the program for a minimum of 1 year can request to re-enroll.
  - Request to enroll by completing the VPLP form and submit to PTU.

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)**

The Family and Medical Leave Act (FMLA) entitles eligible employees with up to 12 work weeks of unpaid, job-protected leave per calendar year (January 1st – December 31st). It also requires that their group health benefits be maintained during the leave.

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons.

Employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- ✓ For the care of the employee's child (birth, placement for adoptions, or foster care);
- ✓ For incapacity due to pregnancy, prenatal medical care or child birth;
- ✓ For the care of the employee's spouse, son or daughter, or parent, who has a serious health condition;
- ✓ For a serious health condition that makes the employee unable to perform his/her job;
- ✓ For qualifying exigencies arising out of the fact that the employee's spouse, son, daughter or parent (the covered military member) is on active duty or has been notified of an impending call or order to active duty in support of a contingency operation.

An eligible employee has the right to

- ✓ have group health insurance maintained during a period of FMLA leave under the same terms and conditions as if the employee had not taken leave and
- ✓ be restored to the same or an equivalent position at the end of the FMLA leave.

**FMLA Notification Required**

If the employee is absent for three consecutive days or if the supervisor becomes aware of the employee's need for leave, notify the FMLA coordinator for eligibility.

**Verify Eligibility**

The Attendance Clerk or supervisor should contact the FMLA coordinator **via e-mail** to verify eligibility by providing the following:

- Employee name
- Division
- Daytime phone number0
- Date leave is to commence
- Reason for leave (i.e., self, family member, birth of child etc.)
    - If need for leave is for a family member, identify the relation of the family member

# Leave of Absence (LOA)/Leave Types *Continue*

### Family Medical Leave Act (FMLA)

Employees' are "eligible" if they have worked for at least one year and for 1,250 hours over the previous 12 months with the same employer (State of California).

The FMLA coordinator will verify employee's eligibility or ineligibility by returning the CalHR 752 (Notice of Eligibility and Right and Responsibilities) to the requestor, employee, and supervisor.

### Forms

Once eligibility has been established, one of the following forms will be provided by the FMLA coordinator with a letter of instructions to the requestor, employee and supervisor via email and sent to the employee's home address:

- CalHR 754 (Employee's Serious Health Condition)
- CalHR 755 (Family Member's Serious Health Condition)
- CalHR 756 (Military Family Leave)
- CalHR 757 (Military Caregiver's Leave)

It is **mandatory** that a letter of acknowledgement provided by the AC or supervisor is signed by the employee and forward to the FMLA coordinator. The letter of acknowledgement can be found in the HR memorandum 11:028 at: (http://www.dgs.ca.gov/ohr/Resources/HRPolicyMemos.aspx)

### Submission

Return the completed certification by 15 calendar days from the date provided on the certification to the FMLA coordinator for **"approval".** The coordinator will complete and return the Designation Notice (CalHR 753) notifying the employee if FMLA is approved or denied to the requestor, employee and supervisor.

### Supervisor's Role

Once approved, the supervisor should meet with the employee and advise of expectations with regard to notification of absences, reporting (call-in) procedures, Project Accounting and Leave (PAL) entries, etc.
The supervisor should coordinate with the AC to ensure employee's leave usage is recorded accurately in PAL or on the STD 634.

### FMLA Coordinator Responsibility

The FMLA Coordinator will track usage of FMLA and inform employee, supervisor and AC when usage has reached close to what was certified, or the 480 hours or 12 work weeks.

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Employee**

Employees may contact their supervisors or the FMLA coordinator for verification of their FMLA hours used.

*Important: DO NOT post PAL of FMLA alias until approval from the coordinator.*

For further information refer to the HR Memorandum 11:028 at:
http://www.dgs.ca.gov/ohr/Resources/HRPolicyMemos.aspx

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Notice of Eligibility AND Rights and Responsibilities**
**CalHR 752 (Front)**

California Department of Human Resources
**Notice of Eligibility AND Rights and Responsibilities**
CalHR 752 (Rev 2/13)

Reset Form | Print Form

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**
**AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)**

**Part A. Notice of Eligibility**

Eligibility does not mean approval. Once we obtain the information from you as specified in Part B, we will inform you within 5 business days, absent extenuating circumstance, whether your leave will be designated FMLA/CFRA leave and count toward your FMLA/CFRA leave entitlement.

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____ Date _____

Division / Unit _____ Daytime Telephone Number _____

SAMPLE

1. We have received your request for leave beginning on _____ through _____ for:

- ☐ The placement of a child for adoption or foster care.
- ☐ The birth of a child and/or to care for such child.
- ☐ Your pregnancy-related disability (includes severe morning sickness, prenatal care, and childbirth-related disability).
- ☐ Your own serious health condition
- ☐ The care of one of the following due to his or her serious health condition:
  - ☐ child/child of domestic partner
  - ☐ spouse
  - ☐ parent
  - ☐ domestic partner
- ☐ Assisting one of the following who is deployed by the military to a foreign country.
  - ☐ child
  - ☐ spouse
  - ☐ parent
- ☐ The care of one of the following who is a covered service member of the United State Armed Forces who has a serious injury or illness incurred in the line of duty while on active duty, or is a veteran of the Armed Forces including the National Guard and Reserves at anytime within 5 years preceding treatment for a serious injury or illness.
  - ☐ child
  - ☐ spouse
  - ☐ parent
  - ☐ next of kin

2. This notice is to inform you that you are eligible for:

☐ FMLA ☐ CFRA

See Part B for Rights and Responsibilities

3. This notice is to inform you that because of one of the following you are Not eligible for:

☐ FMLA ☐ CFRA

(Only one of the following reasons may be checked although you may not be eligible for other reasons.)

- ☐ You have not met the FMLA/CFRA's 12-month length of service requirement. As of the first date of requested leave, you will have approximately _____ months toward this requirement.
- ☐ You have not met the FMLA/CFRA's 1,250 hours worked requirement.

**Part B. Rights and Responsibilities for Taking FMLA/CFRA LEAVE**

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA/CFRA leave, you must return the certification provided. You have 15 calendar days from the above date to provide certification.** If sufficient information is not provided in a timely manner, your leave may be delayed or denied.

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Notice of Eligibility AND Rights and Responsibilities**
**CalHR 752 (Back)**

California Department of Human Resources
**Notice of Eligibility AND Rights and Responsibilities**
CalHR 752 (Rev 2/13) (Page 2)

| Employee Last Name | Employee First Name | Employee Middle Name | Date |
|---|---|---|---|
| | | | |

1. You must provide the information indicated below:

   ☐ Sufficient certification to support your request for leave. A certification form that sets forth the information necessary to support your request is enclosed.

   ☐ Sufficient documentation to establish the required relationship between you and your family member (e.g., birth certificate, adoption papers, or declaration of domestic partnership).

2. ☐ Additional information is needed.

3. ☐ Additional information is not needed

SAMPLE

**FMLA/CFRA Leave**

1. You have a right to take up to 12 weeks of leave in a 12-month period. A 12-month period will be based on a calendar year (January 1 - December 31).

2. You have a right under FMLA military caregiver leave to take up to 26 weeks of unpaid leave in a single 12-month period to care for a covered service member who has a serious injury or illness incurred in the line of duty while on active duty. This 12-month period will commence on the first day of your approved caregiver leave.

3. Your health benefits will be maintained during any period of FMLA/CFRA unpaid leave under the same conditions as if you continued to work.

4. You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA/CFRA-protected leave. (If your leave extends beyond the end of your FMLA/CFRA entitlement, you do not have return rights under FMLA/CFRA.)

5. If you do not return to work following your leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA/CFRA leave; (2) the continuation, recurrence, or onset of a covered service member's serious injury or illness, which would entitle you to FMLA/CFRA leave; or (3) other circumstances beyond your control; you may be required to reimburse the State for the cost of health insurance premiums paid on your behalf during your leave.

6. You have the option to use your sick, vacation, and/or other leave balances, provided you meet any applicable requirements of the Memorandum of Understanding and department leave policies. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA/CFRA leave.

For conditions applicable to sick/vacation/other leave usage, please refer to the Memorandum of Understanding and department policies.

**PRIVACY NOTICE**

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

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Designation Notice**
**CalHR 753**

California Department of Human Resources
**DESIGNATION NOTICE**
CalHR 753 (Rev 2/13)

Reset Form | Print Form

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**
**AND CALIFORNIA FAMILY RIGHTS ACT (CFRA)**

| Employee Last Name | Employee First Name | Employee Middle Name | Date |
|---|---|---|---|
| | | | |

| Division/Unit | Daytime Contact Phone Number |
|---|---|
| | |

**Part A. Leave Approval**

1. Your leave request is approved on a: ☐ Continuous ☐ Intermittent basis From: _____ To _____
2. All leave taken for this reason will be designated as specified (check all that apply)
   ☐ FMLA ☐ CFRA ☐ Military Caregiver Leave ☐ Qualifying Exigency Leave
3. You must notify us as soon as practicable if the dates of your scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information on the time that will be counted against your leave entitlement:
   ☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement:
   ☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your leave entitlement at this time. You have the right to request this information once in a 30 calendar day period (if leave was taken in the 30 calendar day period).
4. Please be advised: (check if applicable):
   ☐ You have requested to use paid leave. Any paid leave taken for this reason will count against your FMLA/CFRA leave entitlement.
   ☐ You will be required to present a return-to-work certification in order to return to work. If such certification is not timely, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ is attached; or ☐ is not attached.
   ☐ Other

**Part B. Additional Information Needed**

Additional information is needed to determine if your FMLA/CFRA leave request can be approved:
☐ The certification you have provided is not complete and sufficient to determine whether the FMLA/CFRA regulations apply to your leave request. You must provide the following information or your leave may be denied. We need the following:
☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense for your serious health condition and we will contact you to provide further details.

**Part C. Leave Denial**

Check all that apply
☐ Your request for the following is not approved:
☐ FMLA ☐ CFRA ☐ Military Caregiver Leave ☐ Qualifying Exigency Leave
☐ The applicable leave regulations do not apply to your request.
☐ Complete and sufficient certification was not provided.
☐ You have exhausted your leave entitlement in the applicable 12-month period.
☐ Other/Comment: _____

| Human Resources Representative Signature: | Date |
|---|---|
| | |

**PRIVACY NOTICE**

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

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA, FMLA Military Caregiver, or FMLA Qualifying Exigency benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Health Care Provider for Employee's Serious Health Condition**
**CalHR 754 (Page 1)**

California Department of Human Resources
**CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION**
CalHR 754 (Rev 2/13)

Reset Form | Print Form

**Family and Medical Leave Act (FMLA)**
**California Family Rights Act (CFRA)**

**Part A: For Completion by the person responsible for administering the leave program in your department who will be the Department Contact.**

**Instructions: Complete Section I before giving this form to the employee.**

Employee Last Name | Employee First Name | Employee Middle Name | Last Day Worked:

Employee Classification | Employee Work Unit

Department Contact | Department Contact Phone

SAMPLE

**Attach a copy of the employee's job description and the essential job functions of the employee's position.**

**Part B: For Completion by the EMPLOYEE**

**Instructions to the Employee:** Part A must be completed by the person responsible for administering the leave program in your department and you must complete Part B before giving this form to your medical provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in denial of your leave request. **You have 15 calendar days to return this form.**

Daytime Contact Phone Number:

Regular Work Schedule
☐ Days ☐ Nights ☐ Full Time ☐ Part Time
☐ 9/80 ☐ 4/10 ☐ Other

**Part C: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS for the HEALTH CARE PROVIDER:** Your patient has requested leave under FMLA/CFRA. Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Please be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate may not be sufficient to determine FLMA/CFRA coverage. **Please do not disclose the underlying diagnosis without the consent of your patient. Please limit responses to the condition for which the employee is seeking leave. Please be sure to sign and date the form on the last page**

Provider Name (You may attach a business card in lieu of completing this section):

Business Address | City | State | Zip Code

Type of Practice / Medical Specialty

Telephone | Fax

**Part D. Medical Facts**

1. Does the patient have a serious health condition that qualifies under the categories described on the attached sheet? ☐ Yes ☐ No
   If no, sign and date page two and return to patient.
2. If the patient has a serious health condition as defined in the attached sheet, please answer the following:
   Approximate Date Condition Commenced: _____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ Yes ☐ No If yes, date of admission _____
4. Dates treated for condition: _____
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ Yes ☐ No If yes, state the frequency and expected duration of such treatment(s): _____

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Health Care Provider for Employee's Serious Health Condition**
**CalHR 754 (Page 2)**

California Department of Human Resources
**CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION**
CalHR 754 (Rev 2/13)(Page 2/Reverse)

Employee Last Name Employee First Name Employee Middle Name

6. Is the employee unable to perform any of the job functions due to his/her medical condition? (See attached Essential Job Functions and/or attached Job Description): ☐ Yes ☐ No
If yes, identify the job functions the employee is unable to perform, work restrictions and probable duration:

7. Can the patient perform modified duty? ☐ Yes ☐ No
If yes, state the type of modified duty the employee is able to perform and probable duration:

SAMPLE

**Part E: Amount of Time Needed**

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No
If yes, estimate the beginning and ending dates for the period of incapacity:

2. Will the employee need to attend follow-up treatment appointments because of the employee's medical condition? ☐ Yes ☐ No
If yes, estimate the schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period

3. Will the employee need to work part time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No
If yes, estimate the part-time or reduced work schedule the employee needs
_____ hour(s) per day; _____ days per week from _____ through_____

4. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No
If yes, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per _____ week (s) _____ month(s)
Duration: hours day(s) per event

**ADDITIONAL INFORMATION (Identify Question Number With Any Additional Information to Your Answers)**

**Signature below verifies that the information provided above is true and accurate**

Printed Name of Health Care Provider

Health Care Provider Signature Date

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Health Care Provider for Employee's Serious Health Condition**
**CalHR 754 (Page 3)**

California Department of Human Resources
**CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION**
CalHR 754 (Rev 2/13)(Page 3/Reverse)

Employee Last Name Employee First Name Employee Middle Name

**Dear Health Care Provider,**

**Do NOT provide the employee's diagnosis.**

The employee has requested leave under the Federal and/or California family and medical leave statutes for his or her own serious health condition.

Thank you for your assistance.

SAMPLE

**Definition of a Serious Health Condition**

Serious health condition is any illness, injury, impairment, physical or mental condition that involves:

1. Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
2. Continuing treatment by a health care provider for one or more of the following:
   a. Any period of incapacity due to pregnancy, for prenatal care.
   b. Any period of incapacity due to a chronic serious health condition that:
      i. Requires periodic ( at least two visit per year) visits for treatment
      ii. Continues over an extended period of time; and
      iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
3. Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease)
4. Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence or medical intervention such as cancer (chemotherapy, radiation, etc., or kidney disease (dialysis) or severe arthritis (physical therapy).

**A Serious Health Condition Is Generally Not:**

1. Allergies, stress, or substance abuse unless inpatient hospital care is provided, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health conditions; or
2 Voluntary treatment or surgery inpatient hospital care is required.

**A Health Care Provider Is:**

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a

1. doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physicians assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner.
2. any provider the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

**PRIVACY NOTICE**

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

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Health Care Provider for Family Member's Serious Health Condition CalHR 755 (Part 1)**

California Department of Human Resources
**Certification of Health Care Provider for Family Member's Serious Health Condition**
CalHR 755 (Rev 2/13)

Reset Form | Print Form

**Family and Medical Leave Act (FMLA)**
**California Family Rights Act (CRFA)**

**Part A: For Completion by the Employee**

**Instructions to the EMPLOYEE:** Please Complete Part A before giving this form to your family member or his/her health care provider. The law permits us to require that you submit a timely, complete, and sufficient medical certification to support a request for leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA/CFRA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. **You have 15 calendar days to return this form.**

Employee Last Name | Employee First Name | Employee Middle Name | Contact Telephone Number

Employee Classification | Employee Work Unit

SAMPLE

Last Day Worked

Regular Work Schedule
☐ Days ☐ Nights ☐ Full Time ☐ Part Time
☐ 9/80 ☐ 4/10 ☐ Other _____

Relation to employee ☐ child/child of domestic partner ☐ spouse ☐ parent ☐ domestic partner

If family member is your son or daughter , date of birth

Name of family member for who you will provide care | Last Name | First Name | Middle Name

Describe the care you will provide to your family member and estimate how much you will need take to provide the care:

Employee Signature: I certify that the information I have provided is true and correct. | Date

**Part B: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS for the HEALTH CARE PROVIDER:** The employee listed above has requested leave under FMLA/CFRA to care for your patient. Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience and examination of the patient. Please be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate may not be sufficient to determine FLMA/CFRA coverage. **Please do not disclose the underlying diagnosis without the consent of your patient. Please limit responses to the condition which the employee is seeking leave for the family member. Please be sure to sign and date the form on the last page.**

Provider Name (You may attach a business card in lieu of completing this section)

Business Address | City | State | Zip Code

Type of Practice / Medical Specialty

Telephone | Fax

**PART C. MEDICAL FACTS**

1. Does the patient have a serious health condition that qualifies under the categories described on the attached sheet?
   ☐ Yes ☐ No If no, sign and date page two and return to patient.
2. If the patient has a serious health condition as defined in the attached sheet, please answer the following:
   Approximate Date Condition Commenced: _____ Probable Duration of Medical Condition or Need for Treatment: _____

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Health Care Provider for Family Member's Serious Health Condition CalHR 755 (Part 2)**

California Department of Human Resources
**Certification of Health Care Provider for Family Member's Serious Health Condition**
CalHR 755 (Rev 2/13)(Page 2)

SAMPLE

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____

3. Dates treated for condition:

4. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

5. Was medication other than over-the-counter medication prescribed? ☐ Yes ☐ No

6. Does the condition of the patient warrant the participation of the employee? (This may include psychological comfort and or arranging for third party care for the family member) ☐ Yes ☐ No

**Part D. Amount of Care Needed** (When answering these questions, keep in mind the patient's need for care by the employee seeking leave that include assistance for basic medical, hygiene, nutritional, safety, transportation needs, the provision of physical or psychological care.)

1. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ Yes ☐ No If yes, state the frequency and expected duration of such treatment(s): _____

2. Will the patient be incapacitated for a **single continuous period** of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No
   If yes, estimate the beginning and ending date for the period of incapacity _____ to _____

3. Will the patient require follow-up treatment, including any recovery time? ☐ Yes ☐ No
   If yes, estimate the schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period _____

4. During this time, will the patient need care which the employee's presence would be beneficial? ☐ Yes ☐ No
   If yes, explain the care needed by the patient and why such care is **medically necessary**
   _____

5. **Please answer the following questions only if the employee is requesting intermittent leave or a reduced work schedule.**
   Is it **medically necessary** for the employee to be off work on an intermittent basis or to work less than the employee's normal work schedule in order to care for the serious health condition of the family member?
   ☐ Yes ☐ No
   If yes, please indicate the estimated number of doctor's visits, and/or estimated duration of medical treatment(s):
   _____ hour(s) per day; _____ days per week from _____ through _____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?
   ☐ Yes ☐ No
   If yes, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (i.e..e, 1 episode every 3 months lasting 1-2 days):
   Frequency: _____ times per _____ week (s) _____ month(s)
   Duration: _____ hours _____ day(s) per event
   Does the patient need care during these flare-ups? ☐ Yes ☐ No

**ADDITIONAL INFORMATION- (Identify Question Number With Any Additional Information to Your Answers) Please attach a separate sheet of paper if additional space is need.**

Signature below verifies that the information provided above is true and accurate.

Health Care Provider Signature _____ Date _____

# Leave of Absence (LOA)/Leave Types *Continue*

## Family Medical Leave Act (FMLA) Continue

### Certification of Health Care Provider for Family Member's Serious Health Condition CalHR 755 (Part 3)

California Department of Human Resources
**Certification of Health Care Provider for**
**Family Member's Serious Health Condition**
CalHR 755 (Rev 2/13)(Page 3)

| Employee Last Name | Employee First Name | Employee Middle Name |
|---|---|---|
| | | |

**Dear Health Care Provider,**

**Do NOT provide the patient's diagnosis without the consent of the patient.**

The employee has requested leave under the Federal and/or California family and medical leave statutes for the purpose of caring for your patient (who is a parent, child or spouse/domestic partner of the employee)

Thank you for your assistance.

SAMPLE

## Definition of a Serious Health Condition

Serious health condition is any illness, injury, impairment, physical or mental condition that involves:

1. Any period of incapacity or treatment in connection with or consequent to an overnight stay in a hospital, hospice, or residential medical care facility; or
2. Continuing treatment by a health care provider for one or more of the following:
   a. Any period of incapacity due to a chronic serious health condition that:
      i. Requires periodic ( at least two visit per year) visits for treatment
      ii. Continues over an extended period of time; and
      iii. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
3. Any period of incapacity which is long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's disease)
4. Any period of absence required to receive multiple treatments (including the period of recovery) either for restorative surgery after an accident or other injury, or for a chronic condition.

## A Serious Health Condition Is Generally Not:

1. Allergies, stress, or substance abuse unless inpatient hospital care is provided, or the patient is incapacitated for more than three calendar days and is under the continuing care of a health care provider, or the patient has a serious long-term health conditions; or
2. Voluntary treatment or surgery inpatient hospital care is required.

## A Health Care Provider Is:

Department of Labor regulations for the Family and Medical Leave Act define a "health care provider" as a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or clinical social worker, physicians assistant, who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the University or the employee's group health plan will accept certification of a serious health condition to substantiate a claim for benefits.

**PRIVACY NOTICE**

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

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Qualifying Exigency for Military Family Leave (Family and Medical Leave Act) CalHR 756 (Font)**

California Department of Human Resources
**CERTIFICATION OF QUALIFYING EXIGENCY FOR MILITARY FAMILY LEAVE**
**(FAMILY AND MEDICAL LEAVE ACT)**
CalHR 756 (Rev 2/13)

Reset Form | Print Form

**QUALIFYING EXIGENCY LEAVE**

**Part A. For Completion by the EMPLOYEE**

**INSTRUCTIONS to EMPLOYEE:** The FMLA permits that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency or deployment to a foreign country. Several questions in this section seek a response as to the frequency or duration of the deployment. Be as specific as you can. Terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. **You have 15 calendar days to return this form.**

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____ Date _____

Division / Unit _____ Number _____

SAMPLE

Name of the covered military member on active duty or call to active duty status:

Last Name _____ First Name _____ Middle Name _____

Your relationship to the covered service member: ☐ Spouse ☐ Parent ☐ Child

Period of military member's active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to active duty or call to active duty status includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation or deployment to a foreign country. Please check one of the following:

- ☐ A copy of the covered military member's active duty orders is attached.
- ☐ Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status.

**Part B. Qualifying Reason for Leave**

1. Describe the specific reason you are requesting FMLA leave due to a qualifying exigency or deployment to a foreign country (attach a separate sheet of paper if additional space is needed):

2. A complete and sufficient certification to support a request for FMLA leave includes any available written documentation which supports the need for leave. Such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached:
   ☐ Yes ☐ No ☐ None Available

**Part C. Amount of Leave Needed**

1. Approximate date exigency or deployment to a foreign country commenced: _____

2. Probable duration of deployment: _____

3. Will you need to be absent from work for a single continuous period of time due to the deployment? ☐ Yes ☐ No
   If Yes, estimate the beginning and ending dates for the period of absence: _____ to _____

4. Will you need to be absent from work periodically to address the deployment? ☐ Yes ☐ No
   If yes, estimate schedule of leave, including the dates of any scheduled meetings or appointments:

5. Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (e.g., 1 deployment-related meeting every month lasting 4 hours):
   Frequency: _____ times per _____ week (s) _____ month(s)
   Duration: _____ hours _____ day(s) per event

# Leave of Absence (LOA)/Leave Types *Continue*

**Family Medical Leave Act (FMLA)** Continue

**Certification of Qualifying Exigency for Military Family Leave (Family and Medical Leave Act) CalHR 756 (Back)**

California Department of Human Resources
**CERTIFICATION OF QUALIFYING EXIGENCY FOR MILITARY FAMILY LEAVE**
**(FAMILY AND MEDICAL LEAVE ACT)**
CalHR 756 (Rev 2/13)

## Part D. Third Party Information

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging, or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (e.g., either the telephone or fax number or e-mail address of the individual or entity). This information may be used to verify the accuracy of the information contained on this form.

SAMPLE

Name of Individual | Title

Organization | Email

Address | City | State | Zip Code

Telephone | Fax

Describe Nature of Meeting

## Part E. Employee Certification

I certify that the information I provided is true and correct.
Signature of Employee | Date

### PRIVACY NOTICE

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

Information requested on this form is used by your department for purposes of determining your eligibility for FMLA/CFRA benefits. It is mandatory to furnish all information requested on this form. Failure to provide the mandatory information may result in a delay in processing your request.

# Leave of Absence (LOA)/Leave Types *Continue*

## Family Medical Leave Act (FMLA) Continue

### Certification for Serious Injury or Illness of Covered Service Member for Military FAMILY Caregiver Leave (Family and Medical Leave Act) CalHR 757 (Front)

California Department of Human Resources
**Certification for Serious Injury or Illness of Covered** Servicemember
**For Military FAMILY Caregiver Leave (Family and Medical Leave Act)**
CalHR 757 (Rev 2/13)

Reset Form | Print Form

**MILITARY CAREGIVER LEAVE**

**Part A: For Completion by the EMPLOYEE**

Employee Last Name _____ Employee First Name _____ Employee Middle Name _____ Contact Telephone Number _____

Employee Work Unit _____

Name of covered servicemember for whom employee is requesting Caregiver Leave: (Last, First, Middle) Last Name _____ First Name _____ Middle Name _____

Your relationship to the covered servicemember: ☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin

**Part B. Covered Servicemember Information**

1. Is the covered servicemember a current member of the Regular Armed Forces, the National Guard, Reserves or a Veteran of the Armed Forces including the National Guard and Reserves at any time within 5 years preceding treatment? ☐ Yes ☐ No

   If Yes, please provide the covered servicemember's Military Branch _____ Rank _____ Unit currently assigned if applicable _____

2. Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No

   If Yes, please provide the name of the medical treatment facility or Unit: _____

3. Is the covered servicemember on the Temporary Disability Retired List? ☐ Yes ☐ No

**Part C. Care to be Provided to the Covered Servicemember**

1. Describe the care to be provided to the covered servicemember.

2. Estimate the amount of leave needed to provide care.

Part D. For Completion by the HEALTH CARE PROVIDER

For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (VA) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). **Please ensure that Parts A, B, and C above are completed before completing this section. Please be sure to sign and date the form on the last page**

Provider Name (You may attach a business card in lieu of completing this section): _____

Business Address _____ City _____ State _____ Zip Code _____

Type of Practice / Medical Specialty _____

Telephone _____ Fax _____

1. Covered servicemember's medical condition is classified as: (Check One)
   - ☐ **(VSI) Very seriously ill/injured** - illness/injury is of such a severity that life is imminently endangered. Family is requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)
   - ☐ **(SI) Seriously ill/injured** - illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)
   - ☐ **OTHER ill/injured** - a serious injury or illness that may render the service member medically unfit to perform the duties of the member's office, grade, rank, or rating.
   - ☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such a leave is requested, you may be required to complete the applicable request form.)
2. Was the condition for which the covered servicemember is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No
3. Approximate date condition commenced _____
4. Probable duration of condition and/or need for care _____
5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No

   If yes, please describe the medical treatment, recuperation, or therapy: _____

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

## Family Medical Leave Act (FMLA) Continue

### Certification for Serious Injury or Illness of Covered Service Member for Military FAMILY Caregiver Leave (Family and Medical Leave Act)

### CalHR 757 (Back)

California Department of Human Resources

**Certification for Serious Injury or Illness of Covered Service member**
**For Military FAMILY Caregiver Leave (Family and Medical Leave Act)**
CalHR 757 (Rev 2/13) (Page 2)

| **Part F. Covered Servicemember's Need for Care by Family Member** | |
|---|---|
| 1. | Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No<br>If Yes, estimate the beginning and ending dates for this period of time _____ to _____ |
| 2. | Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No<br>If Yes, estimate the treatment schedule |
| 3. | Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No |
| 4. | Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medication condition)? ☐ Yes ☐ No |
| | If Yes, please estimate the frequency and duration of the periodic care _____ |
| **Part G. Signature** | |
| Printed Name of Health Care Provider _____ | |
| Health Care Provider Signature _____ | Date/Time _____ |
| **Privacy Notice**<br>The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 92-579) requires this notice be provided when collecting personal information from individuals. | |

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

## Family Medical Leave Act (FMLA) Continue

### Letter of Acknowledgement

State of California • State and Consumer Services Agency • Edmund G. Brown Jr, Governor
**DEPARTMENT OF GENERAL SERVICES**
**Administration Division Office of Human Resources**

## ACKNOWLEDGEMENT OF RECEIPT

**SAMPLE**

**DATE:**

**EMPLOYEE:**

I acknowledge receipt of a Family Medical Leave Packet.

The Family Medical Leave packet was provided to me on the above stated date by _____.
(Insert name of person providing packet)

I understand that it is my responsibility to provide my supervisor with the completed packet should I request Family Medical Leave.

I understand that by receiving this packet there is no representation that I am eligible or that I qualify for leave.

I understand that if I have questions or concerns at any time about Family Medical Leave I will consult my immediate supervisor, my supervisor's manager or the Office of Human Resources Medical Coordinator at (916) 376-5424.

_____
**EMPLOYEE PRINTED NAME**

_____
**EMPLOYEE SIGNATURE**

_____
**DATE**

_____
**SIGNATURE OF PACKET PROVIDER**

_____
**DATE**

The Ziggurat • 707 Third Street, Suite 7-130 • PO Box 989052 • West Sacramento, CA 95798-9052 • (916) 376-5400

# Leave of Absence (LOA)/Leave Types *Continue*

### Catastrophic Leave (CAT LV)

It is the policy of DGS to grant catastrophic leave to all employees when an employee has exhausted all leave credits and is facing financial hardship due to a catastrophic injury or prolonged illness of him/herself or his/her family member, for parental leave or adoption leave, or due to the effect of a natural disaster by providing donations and transfer of eligible leave credits from other employees.

Employees who have exhausted their leave credits due to a catastrophic event can request catastrophic leave. In such cases, DGS will set up a Catastrophic Leave bank for the employee to receive donated leave from other State employees. Donations are irrevocable but personnel offices may make exceptions if the donated time is not used.

### Catastrophic Injury or Illness

An injury or prolonged illness which incapacitates the employee and creates a financial hardship because the employee has exhausted all sick leave and other paid time off. Any injury or prolonged illness may also include a family member per individual bargaining unit or DPA rule.

Catastrophic leave permits salary and benefit continuation for employees who have exhausted all paid leave because of a serious injury or illness or the need to care for a seriously injured or ill family member.

### Catastrophic Natural Disaster

This benefit is also available to an employee who has exhausted all leave credits, except sick leave, who resides in a county where the Governor has declared a State of Emergency because of a natural disaster.

### Donations

Donated leave credits will be transferred in **one-hour** increments and used only when needed. Unused donated leave credits will be returned to the donor in 30 days. Leave credits that may be transferred include:

- Vacation
- Annual Leave
- Compensating Time Off (CTO)
- Holiday Credits
- And under certain bargaining unit agreements, Personal Holiday Credits.

Donations will be credited as Vacation or Annual leave as applicable.

Refer to the Memorandum's of Understanding (MOUs) for current incremental donations to transfer.

***Important!*** **Sick Leave may not be transferred and as the receiving department, DGS does not accept donations of personal leave.**

# Leave of Absence (LOA)/Leave Types *Continue*

## Catastrophic Leave (CAT) Continue

### Transfer of Leave Credits

Upon request of an employee and upon approval of the Catastrophic Leave Coordinator/Personnel Officer:

| Leave Credits Shall be Transferred… | For Issues Relating to… |
|---|---|
| Between family members | • Family Medical Leave (FMLA)<br>• Parental leave<br>• Adoption Leave |
| From one or more employees to another employee | Receiving employee faces financial hardship due to injury or prolonged illness of the:<br><br>• Employee or<br>• Employee's child, parent, spouse, domestic partner, spouse's parent or domestic partner's parent, brother, sister or other person residing in the same household. |

### Eligibility

All State employees are eligible. Eligible leave credits may be transferred to a family member or to another employee who is on leave for a serious health condition, or for parental or adoption leave. Under this program, employees do not have to suffer a financial hardship to be eligible to receive donated leave credits.

| Employee's CBID | May Donate to… | Use of Donated Credits Up To… |
|---|---|---|
| Represented Employees | Represented and Excluded employees which includes classes designated by a CBID "U," "C"; "M" (managerial defined in GC 3513e) or "S" (supervisory defined in GC 3522.1) | Three (3) months period annually. If approved by the Personnel Officer, may be used up to six (6) months. |
| Excluded Employees | Represented and non-represented/Excluded employees | Up to 12 continuous months for a single occurrence. |

There is no minimum State service requirement for eligibility.

# Leave of Absence (LOA)/Leave Types *Continue*

## Catastrophic Leave (CAT LV) Continue

### Eligibility Continued

Participation in the Catastrophic Leave (CAT LV) program may be authorized if all the following conditions are met:

- The employee faces financial hardship due to injury or prolonged illness of the employee or eligible family member, or due to a natural disaster.
- The employee has exhausted all leave credits (with the exception of sick leave in the case of a natural disaster).
- The employee's request (DGS OHR 903) to participate in the CAT LV program has been reviewed by the employee's supervisor and approved by the Catastrophic Leave Coordinator and Personnel Officer.
- MOUs do not provide for retroactive approval of CAT LV.

If the employee is unavailable or incapacitated, a co-worker, family member, or other representative may file the request on the individual's behalf if written permission is granted by the employee.

### Authorized Reasons

For the purposes of transferring leave credits the following definitions shall apply:

| Donating Employee (Donor) Must… | Receiving Employee (Recipient) Must… |
|---|---|
| maintain a minimum balance of 80 hours of paid leave time (PML 2001-043) | have exhausted all leave credits |
| Donate a minimum of one (1) hour and thereafter, in whole hour increments (Refer to MOUs) | use donations based on date and time received (first in, first used). Unused donations will be returned to the donor in 30 days |

### Excluded Employees

If a department has approved a catastrophic leave request, an excluded employee may transfer vacation, annual leave, compensating time off or holiday leave credits to another employee who has suffered a catastrophic illness or injury or is unable to work due to the effect of a natural disaster on the employee's principal residence. An excluded employee may also receive catastrophic leave donations from other employees. The recipient employee must have exhausted all of his/her available leave to be eligible.

Managerial/Supervisory employees may not receive donations from a represented employee except in cases of extreme hardship as approved by CalHR.

For additional information, please refer to the Compensation Plus handbook via this link: DPA - Compensation Plus

***Reference:*** **DPA Rule 599.925 – 599.925.1**

# Leave of Absence (LOA)/Leave Types *Continue*

## Catastrophic Leave (CAT LV) Continue

### Employee

In order to participate in the CAT program, an employee must submit:

- a completed "Catastrophic Leave Request" form, DGS OHR 903, to his/her supervisor for authorization to receive donated leave credits, which includes physician's verification of the injury or illness. This should include the general nature of the illness or injury but not the diagnosis. The name and relationship of the person incapacitated if a family member, an estimate total time needed and estimate of their current leave balance.
- In the case of a natural disaster, documentation that a "State of Emergency" has been declared by the Governor, which states the county affected, should accompany the request.
- If the request is for transferring leave credits between family members, the required substantiation must be provided as specified in the appropriate Memoranda of Understanding (MOU) or CalHR Rule for the type of leave being used, e.g., Family Medical Leave, parental leave, etc.

If the original time period authorized for receipt of donated leave credits is subsequently determined inadequate, a request for authorization to receive additional time, accompanied by a physician's verification that additional time off for the catastrophic illness or injury is necessary, may be submitted by the employee for consideration. The approval for receipt of additional leave credits, when added to the credits already received, shall not exceed the maximum time limits.

### Medical Substantiation

A physician's verification of the employee or the family member, which includes the general nature of the catastrophic injury or illness (not a description of illness, condition or diagnosis) and the prognosis (anticipated length of absence or estimated return date). If catastrophic leave is required due to the injury or illness of the employee's family member, the medical substantiation must include verification that the employee is needed to provide the care.

### Supervisor

It is the employee's supervisor responsibility to review the request for CAT LV (DGS OHR 903), the Department's policy and appropriate bargaining unit agreement (if the employee is represented). If all criteria of the policy are met, the supervisor will prepare the Supervisor Request for Catastrophic Leave Bank and forwards with the DGS OHR 903 and supporting documents to the Catastrophic Coordinator in Office of Human Resources (OHR). Once the request is approved by the Personnel Officer (PO), the supervisor will be provided a date of when all contribution must be received in OHR and will prepare and circulate the Solicitation for Catastrophic Leave Donation. If the employee requires more leave time than was originally donated, authorization from the PO must be provided before a second memo may be circulated soliciting donations. The procedure for sending the CAT Leave memo is available via this link: CAT Leave Request Procedure or *see* ***"Publicizing the CAT request"*** in the AC manual.

# Leave of Absence (LOA)/Leave Types *Continue*

## Catastrophic Leave (CAT LV) Continue

### Catastrophic Leave Coordinator

Request for CAT and supporting documentation is submitted to the Catastrophic Coordinator for review to assure compliance with the applicable provisions and bargaining unit agreement. The Personnel Specialist will be contacted by the CAT coordinator to verify actual leave balances. After the review, documents will be forward to the Personnel Officer providing the findings to include the actual leave balances and a calculation of the actual time needed.

### Personnel Officer (PO)

If the CAT request meets the requirements of the policy, the employee's supervisor will be notified of the approval by the PO. The PO will agree on the size of the group from which to solicit contributions and agrees to a date all contributions must be received in OHR. If the request does not meet one or more of the requirements, the employee will be notified in writing and routes a copy to the supervisor. The PO will reach an agreement with the supervisor on appropriateness of extending leave. If a second circulation memo needs circulation, the PO will provide authorization to the supervisor to do so. Authorization for additional withdrawals must be approved by the PO if donated credits remain that may be applied.

### Attendance Clerks (AC)

When an employee is out on CAT the AC will complete the employee's PAL, recorded any time worked and earned credits used. For leave taken, record catastrophic leave if no accumulated credits remain. Submits PAL to employee's supervisor for regular monthly processing.

If the request for CAT is submitted to the AC, forward to the employee's supervisor.

### Donating Employees

An employee who would like to participate in donating to an employee, who is on CAT, must complete the contribution CAT Leave Donation Record form (DGS OHR 905) and routes the donation form to their Office of Human Resources and advise their supervisor of the amount of time transferred. The recipient Personnel Specialist must receive the DGS OHR 905 prior to the noted due date.

### Donations

Eligible leave credits may be donated in accordance with DPA rule and individual bargaining unit agreements. Employees wishing to donate leave credits must:

- Submit a completed DGS OHR 905, "Catastrophic Leave Donation Record Form" to the donor's Personnel Specialist, and
- Have sufficient leave credits to cover the donation.

*The criteria for approval are described in DPA Rules 599.925, 599.925.1, and the appropriate MOU.*

# Leave of Absence (LOA)/Leave Types *Continue*

## Catastrophic Leave (CAT LV) Continue

**Publicizing the CAT request**
The employee's need for donated leave credits is publicized in the form of a memorandum signed by the respective Office Chief and addressed to DGS employees. Distribution is accomplished by following the "Procedure for Sending Catastrophic Leave Requests" established by the Enterprise Technology Solutions (ETS formerly ITS)

http://www.documents.dgs.ca.gov/ohr/pom/Procedure4SendingCATleaverequests.pdf

- The memorandum should include the employee's name, branch/office/unit, number of hours being requested, and bargaining unit or non-represented status (see sample of Catastrophic Leave Announcement).
- The memo should NOT specifically address the nature of the employee's injury or illness.

The requesting employee's Attendance Clerk distributes the announcement as appropriate, based on input from the employee. If the employee is requesting donations from other departments, a hard copy of the memorandum and "Catastrophic Leave Donation Record" (DGS OHR 905) will be sent to the participating departments.

**PTU – Personnel Specialist (PS)**

Upon receipt of the CAT forms, the Personnel Specialist in PTU processes the donations in accordance with policy. When PAL is received, the PS will determine how much catastrophic leave will need to be utilized. Donation will be processed in order of receipt and verification of leave balance record of donor (if DGS employee). If the donor is not a DGS employee, the PS will contact the appropriate department of the donor's personnel office for credits to be deducted. A list of names of all non-anonymous donors will be sent to recipient. Donations will be process ONLY to cover the leave deficiency. When completed, the adjustment made will be noted on the donation form and a copy will be return to the donor as verification of the credits transferred. The original DGS OHR 905 will be filed in employee's Official Personnel File. The remaining copy will be forward to donor agency if the employee does not work for DGS. If the employee returns to work as planned, returns unused donations to donors with a notation as to why they were not needed. If employee needs additional time, requests instructions from the Personnel Officer.

*If a donation is received **after** the due date it will be return to the donor with a notation as to why it was not processed.*

# Leave of Absence (LOA)/Leave Types *Continue*

## Catastrophic Leave (CAT LV) Continue

### Inter-Departmental

Transfer of eligible leave credits between departments is permissible in accordance with the policies and procedures of the receiving employee's department. The PS will coordinate interdepartmental transfer of leave credits with the Personnel Office involved to ensure a smooth and accurate transfer of leave credits.

### Periodic Absences

When, and if, an employee has an ongoing medical condition that requires periodic absences from work, e.g., to attend medical appointments, the employee may request/use CAT for this purpose. The conditions are that the employee does not break the continuity of the CAT with dock, the employee uses all accrued leave credits before using CAT credits, and continues to work when not using accrued leave credits or CAT credits.

### EE On Disability

Donated leave credits may be used to supplement Non-industrial Disability Insurance (NDI), Industrial Disability Leave (IDL), and Workers' Compensation Temporary Disability Leave in accordance with existing DGS policy and procedures. Employees who have leave credits restored as a result of IDL approval will retain the donated leave credits previously received for future supplementation.

Employees receiving CAT donations earn state service, retirement benefits, and continue to accrue leave credits. However, as in extended use of leave cases, probationary periods, Special-In-Grade-Salary Adjustments (SISA), Merit Salary Adjustments (MSA), and range changes may be affected by a prolonged absence.

### Termination

Participation is terminated when one or more of the following has occurred:

- The specific need no longer exists. The participating employee's supervisor will notify the Attendance Clerk when the need no longer exists, who in turn notifies the PS.
- The employee has received and used donations for the maximum time limits allowed. Three months or, upon approval, up to six months for a represented employee. No more than 12 continuous months for a non-represented employee.

Upon termination of the employee's participation the Attendance Clerk will notify the affected employee and PS that leave credits are no longer being transferred.

# Leave of Absence (LOA)/Leave Types *Continue*

**Catastrophic Leave (CAT LV)** Continue
**Sample of [Catastrophic Leave Request form DGS OHR 903]**

STATE OF CALIFORNIA
**CATASTROPHIC LEAVE REQUEST**
GS-903 (Rev 10/14)

DEPARTMENT OF GENERAL SERVICES

INSTRUCTIONS:
1. Read the entire employee statement
2. Attach doctors' certification
3. Date and sign form
4. Submit to requesting Employee's Supervisor

EMPLOYEE STATEMENT

- I request to participate in the Catastrophic Leave Program to permit donations of leave credits to my leave balances.
- I or a family member have suffered a catastrophic illness or injury. I have attached a doctor's certification to this request.
- I allow the Department of General Services to use my name to publicize my need for donated credits.
- I understand that this request is not subject to the grievance and arbitration procedures.

SAMPLE

| EMPLOYEE OR LEGAL REPRESENTATIVE SIGNATURE | DATE |
|---|---|
| | |

| TO BE COMPLETED BY EMPLOYING OFFICE | | |
|---|---|---|
| EMPLOYEE NAME (Last, First, Middle Initial) | POSITION NUMBER | CITY EMPLOYED IN |
| ☐ REPRESENTED<br>☐ NON-REPRESENTED | CBID | DATE LEAVE BALANCES EXPIRED |

| TO BE COMPLETED BY THE OFFICE OF HUMAN RESOURCES | | | | |
|---|---|---|---|---|
| ☐ APPROVED FROM: | BEGINNING DATE | ENDING DATE | TOTAL HOURS | ☐ DENIED |
| PERSONNEL OFFICER SIGNATURE | DATE | | | |

Copy to: Personnel Transactions Unit
Office Chief
Requesting Employee

# Leave of Absence (LOA)/Leave Types *Continue*

**Catastrophic Leave (CAT LV)** Continue

**Sample of [Catastrophic Leave Donation Record DGS OHR 905]**

STATE OF CALIFORNIA
**CATASTROPHIC LEAVE DONATION RECORD**
GS 905 (Rev 10/14)

DEPARTMENT OF GENERAL SERVICES

**A. DONOR'S INFORMATION**

The following is a request to participate in the program checked. I have reviewed the applicable Bargaining Unit Agreement or CalHR rule prior to completing this form.

☐ Catastrophic Leave Program ☐ Transfer of Leave Credits for Family Members

NAME DEPARTMENT/UNIT

WORK PHONE EMAIL BARGAINING UNIT (CBID)

SAMPLE

I wish to donate the following leave hours to the above named recipient:

| | | | |
|---|---|---|---|
| | Vacation | | Personal Holiday |
| | Annual Leave | | CTO |
| | Holiday Credit | | |

**I understand this donation is voluntary and my decision is irrevocable**

DONOR'S SIGNATURE DATE

**B. RECIPIENT'S INFORMATION**

NAME DEPARTMENT/UNIT

**C. DONOR'S PERSONNEL OFFICE INFORMATION**

Total hours authorized for transfer:

| | | | |
|---|---|---|---|
| | Vacation | | Personal Holiday |
| | Annual Leave | | CTO |
| | Holiday Credit | | |

I have verified the above named donor has enough leave credits to transfer to the recipient.
I have deducted those hours from the donor's leave balance.

SIGNATURE TITLE DATE

NAME PHONE NUMBER OR EMAIL

**Please send the completed form to:**
DGS – Office of Human Resources, 707 Third St. 7th Floor, West Sacramento, CA 95605

**D. DGS PERSONNEL OFFICE INFORMATION**

I have transferred the credits authorized above to the named recipient

PERSONNEL SPECIALIST SIGNATURE DATE

COPIES: DONOR AGENCY DGS PROGRAM OFFICE
DONOR AGENCY TO PROVIDE COPY TO DONOR

# Leave of Absence (LOA)/Leave Types *Continue*

**Catastrophic Leave (CAT LV)** Continue

**Sample of Supervisor Request for Catastrophic Leave Bank**

DGS CALIFORNIA DEPARTMENT OF GENERAL SERVICES

Governor Edmund G. Brown Jr.

**Date:**

**To:** **Office of Human Resources**
**Return to Work**
**Medical Coordinator**

**From:** SAMPLE

**Subject:** SUPERVISOR'S REQUEST FOR CATASTROPHIC LEAVE BANK

I am requesting a catastrophic leave bank be established for **(EMPLOYEE NAME)** because a recent illness/injury has caused a significant financial hardship. I have reviewed his/her request, and have determined that this employee is unable to work and that leave credits are or will be exhausted by **(DATE)**. It is anticipated that **(XXX)** hours will be needed.

I have attached for your review a copy of the Catastrophic Leave Request form, a verification of the illness or injury, and the "Request for Catastrophic Leave Donations" memorandum.

Upon approval of this request, I will circulate the "Request for Catastrophic Leave Donations" memorandum to all employees.

APPROVAL:

_____ Date:_____
Medical Coordinator

_____ Date:_____
Personnel Officer

# Leave of Absence (LOA)/Leave Types *Continue*

**Catastrophic Leave (CAT LV)** Continue

**Sample of Catastrophic Leave Announcement**

DGS CALIFORNIA DEPARTMENT OF GENERAL SERVICES

Governor Edmund G. Brown Jr.

SAMPLE

**Date:**

**To:** **All General Services Employees**

**From:** **Department of General Services**
*****INSERT PROGRAM INFORMATION*****

**Subject:** **REQUEST FOR CATASTROPHIC LEAVE DONATIONS**

**INSERT EMPLOYEE NAME,** an employee in the **INSERT OFFICE NAME** has requested Catastrophic Leave as authorized by provisions of the Memorandum of Understanding (MOU) and Department of Personnel Administration regulations.

The Catastrophic Leave Program permits the transfer of eligible leave credits (vacation, annual leave, holiday credits and CTO) to an employee when a catastrophic illness occurs. Sick Leave may NOT be donated.

If you wish to contribute leave credits, please complete the attached Catastrophic Leave Donation form, designating the amount and type of leave credits you are donating and return the form to your attendance clerk. Donations must be in whole hour increments. Represented employees may receive donations from non-represented employees.

It is anticipated **XXX** hours will be needed from **(INSERT DATES OF LEAVE).** Donations must be received by **(INSERT DUE DATE FROM OHR).**

Please contact your attendance clerk if you have any questions regarding your leave balances or the process to transfer leave credits.

On behalf of **INSERT EMPLOYEE NAME,** I would like to thank you in advance for your contributions.

**SIGNATURE BLOCK**

Office of Human Resources | State of California | Government Operations Agency
707 3rd Street, 7th Floor | West Sacramento, CA 95605 | t 916.376-5000 f 916.376-5393

# Leave of Absence (LOA)/Leave Types *Continue*

**Attendance Clerk's Responsibilities**

Upon notification that an employee will be out on a possible leave of absence, all Attendance Clerks are expected to follow the steps outlined below.

Document any or all communication received when an employee gives notice of his/her intent to:

- take a leave of absence from work and/or
- file for NDI, SDI or IDL benefits

Contact and communicate the employee's type of leave request and effective dates to the assigned Personnel Specialist, Disability Unit Specialist or Return to Work Clerk (RTW) immediately upon the date of knowledge.

Refer to the table below for the appropriate contact persons based on the type of leave.

| **If the leave type is …** | **Then notify the…** |
|---|---|
| Parental Leave | FMLA Coordinator |
| FMLA | FMLA Coordinator |
| Bereavement Leave | Personnel Specialist |
| CAT Leave | CAT LV Coordinator |
| Military Leave | Personnel Specialist |
| Non-Industrial Disability (NDI) | Disability Unit Analyst |
| State Disability (SDI) | Disability Unit Analyst |
| Worker's Compensation (IDL) | RTW Coordinator |

Assist the employee in completing the necessary forms required to initiate their leave request or disability claim.

***Note:* A listing of forms to be completed for the corresponding leave type is identified in this manual section.**

Respond to employees' inquiries to the best of your ability by providing them with accurate information.

# Leave of Absence (LOA)/Leave Types *Continue*

**Attendance Clerk's Responsibilities** Continue

**Documents To Be Completed**

The table below identifies the initial documents that need to be completed by the employee, reviewed by the AC and submitted to the appropriate persons/units in OHR.

| Type of Leave | Required Documents | Submit to / Notify |
|---|---|---|
| FMLA | AC or employee's manager must immediately notify the FMLA Coordinator to verify the employee's FMLA eligibility | FMLA Coordinator |
| Bereavement Leave (BL) | Employee's written/verbal request for BL; requires supervisor's approval | PTU Specialist |
| Catastrophic Leave (CAT) | Employee's written request for CAT leave; requires Office Chief or Designee approval on the DGS OHR 903 | CAT LV Coordinator |
| Military Leave | Military Orders | PTU Specialist |
| NDI | DE 8501 – First Claim for NDI | Disability Unit Specialist |
| SDI | DE 2501 - Claim for Disability Insurance Benefits (sample of form on page 51) | Disability Unit Specialist |
| IDL | SCIF 3301- Employee's Claim Form - SCIF 3067 - Employer's First Report of Injury or Illness | RTW Coordinator |

# Leave of Absence (LOA)/Leave Types *Continue*

**Sample of First Claim for NDI Form – DE 8501**

Employment Development Department
State of California

## First Claim for Nonindustrial Disability Insurance (NDI)

**NOTE TO NDI APPLICANTS: KEEP THIS INSTRUCTION & INFORMATION JACKET FOR REFERENCE**

**To qualify for NDI benefits, you must be:**

1. A California State government employee

   and

2. Unable to perform your job duties because of a non-work-related disability. (See "Nonindustrial Disability Insurance Provisions," DE 2502 for details.)

SAMPLE

**How to complete the NDI claim form, DE 8501:**

1. Have your Attendance Clerk or Payroll Officer complete Part A.
2. Complete all items in Part B when you have stopped working due to a disability.
3. Give this claim form to your doctor for completion of Part C. (If you are under the care of an accredited religious practitioner, ask your practitioner to complete and sign a "Practitioner's Certificate," DE 2502, available from any State Disability Insurance office.)
4. Advise your doctor that upon completion of the medical certificate the claim form should be forwarded ONLY to the NDI office indicated below.

**Note:** It is the employee's responsibility to see that this Claim and the Doctor's Certificate are filled out COMPLETELY and mailed to the Employment Development Department address listed below. If you do not understand this form, you may call the NDI office at **866-758-9768**. If any item is not completed on this form, it may be returned for completion and your benefit payment may be delayed.

If an authorized agent is filing for benefits for a PHYSICALLY INCAPACITATED, MENTALLY INCAPACITATED, or DECEASED claimant, contact any State Disability Insurance office or call 1-800-480-3287 for the required forms and instructions.

| | |
|---|---|
| **MAIL COMPLETED FORM TO:** | **State of California**<br>**Employment Development Department**<br>**N D I**<br>**P.O. Box 2168**<br>**Stockton CA 95201-2168** |

# Leave of Absence (LOA)/Leave Types *Continue*

**Sample of First Claim for NDI Form – DE 8501** Continue

### Information Collection and Access

State law requires the following information to be provided when collecting information from individuals:

| | |
|---|---|
| **Agency Name:**<br>Employment Development Department (EDD) | **Title of Official Responsible for Information Maintenance:**<br>Manager, EDD Disability Insurance Office |
| **Local Contact Person:**<br>Manager, EDD Disability Insurance Office | **Address and Telephone Number:**<br>528 North Madison, Stockton, CA 95202-1917 866-758-9768 |

**Maintenance of the Information is authorized by:**
California Unemployment Insurance Code, sections 2601 through 3272.
California Code of Regulations, title 22, sections 2706-1, 2706-3, 2708.1-1, 2710-1.
California Government Code, sections 19878 through 19886.2.

**All information requested is mandatory. Consequences of not providing all or any part of the requested information:**

- Failure to supply any or all information may cause a delay in issuing benefit checks or may cause you to be denied benefits to which you are entitled.
- If you willfully make a false statement or representation or knowingly withhold a material fact to obtain or increase any benefit or payment, EDD will disqualify you from receiving benefits any/or services and may initiate criminal prosecution against you.
- EDD may require an independent medical examination to determine your initial or continuing eligibility.

**Principal purpose(s) for which the information is to be used:**

- To determine eligibility for nonindustrial disability insurance benefits.
- To be summarized and published in statistical form for the use and information of government agencies and the public. (Your name and identification will not appear in publications.)
- To be used to locate persons who are being sought for failure to provide child or spousal support.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of California Welfare and Institutions Code, division 9.
- To be used by EDD to carry out its responsibilities under the California Unemployment Insurance Code.
- To be exchanged pursuant to California Unemployment Insurance Code, section 322, and California Civil Code, section 1798.24, with other governmental departments and agencies, both federal and state, which are concerned with any of the following:
  (1) administration of an unemployment insurance program;
  (2) collection of taxes which may be used to finance unemployment insurance or disability insurance;
  (3) relief of unemployed or destitute individuals;
  (4) investigation of labor law violations or allegations of unlawful employment discrimination;
  (5) the hearing of workers' compensation appeals;
  (6) whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered; or
  (7) when mandated by state or federal law. Disclosures under California Unemployment Insurance Code, section 322, will be made only in those instances in which it furthers the administration of the programs mandated by that Code.
- Pursuant to California Unemployment Insurance Code, sections 1095 2714:
  (1) Information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his/her representatives;
  (2) Claimant identity may be released to the Department of Rehabilitation.
- Information shall be disclosed to authorized agencies in accordance with California Unemployment Insurance Code, sections 1095 and 2714.

Under California Civil Code, section 1798.34, you have the right to inspect records maintained on you by the agency unless exempted as described on page C.

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

**Sample of First Claim for NDI Form – DE 8501** Continue

EDD Employment Development Department State of California

## First Claim for Nonindustrial Disability Insurance (NDI)

**Attendance Clerk or Payroll Officer:**

Please complete Part A before giving or sending this form to the employee.

**Part A - Employer Information**

1. NAME OF EMPLOYEE (EE) — FIRST / INITIAL / LAST
2. SOCIAL SECURITY NUMBER
3. POSITION NUMBER — AGENCY / UNIT / CLASS / SERIAL
3. GENDER — ☐ MALE ☐ FEMALE
4. OCCUPATION
5. CBID #
6. GROSS MONTHLY SALARY $
7. LAST DAY PHYSICALLY WORKED / /

SAMPLE

8. PERSONNEL TRANSACTIONS UNIT (PTU) OR SECTION RESPONSIBLE FOR EMPLOYEE'S PAYROLL DOCUMENT
DEPARTMENT OR CAMPUS
PTU OR SECTION
MAILING ADDRESS
NAME OF PAYROLL SPECIALIST (PLEASE PRINT)
PUBLIC PHONE ( ) / EXTENSION / FAX ( )

APPOINTMENT/TIME BASE STATUS (CHECK ALL THAT APPLY)
☐ PERMANENT/PROBATIONARY
☐ FULL TIME
☐ PT/INT – DID EE HAVE EQUIVALENT OF 6 MONTHLY COMPENSATED PPS IN THE PAST 18 PPS? ☐YES ☐NO
☐ PERS/STRS MEMBER
☐ LT – DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ☐YES ☐NO
☐ TALI – DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ☐YES ☐NO
☐ CEA – DOES EE HAVE THE RIGHT TO RETURN TO A PRIOR PERMANENT, FULL-TIME POSITION? ☐YES ☐NO
☐ LEAP – HAS EE SUCCESSFULLY COMPLETED THE TEMPORARY JOB EXAMINATION PERIOD? ☐YES ☐NO
☐ SEASONAL
☐ ANNUITANT
☐ EMERGENCY

10. DID EE LEAVE WORK BECAUSE OF SICKNESS, INJURY, SURGERY, OR PREGNANCY? ☐YES ☐NO
IF NO," PLEASE GIVE REASON (SEPARATION, LAYOFF, RETIREMENT, LOA, SUSPENSION, ETC.)

11. EXEMPT EE? ☐YES ☐NO
12. IS EE REQUIRED TO EXHAUST SICK LEAVE? ☐YES ☐NO
IS EE ENROLLED IN THE ANNUAL LEAVE PROGRAM? ☐YES ☐NO

13. ADDRESS OR LOCATION WHERE EMPLOYEE ACTUALLY WORKS

14. FOR ANNUAL LEAVE PROGRAM (ALP) EMPLOYEES:
IS EE SUPPLEMENTING NDI WITH ANNUAL LEAVE? ☐YES ☐NO
DID EE ELECT TO USE FULL LEAVE CREDITS, INCLUDING CATASTROPHIC LEAVE? ☐YES ☐NO
IF "YES," LEAVE CREDITS ARE TO BE PAID THROUGH _____ (DATE)

16. FOR NON-ALP EMPLOYEES:
DID EE ELECT TO USE FULL LEAVE CREDITS, INCLUDING CATASTROPHIC LEAVE? ☐YES ☐NO
IF "YES," LEAVE CREDITS ARE TO BE PAID THROUGH
LAST DATE PAID / HOURS PAID ON THAT DAY

15. COMPLETED BY (PLEASE PRINT NAME) / DATE COMPLETED
SIGNATURE
PUBLIC PHONE ( ) / EXTENSION / FAX ( )

17. WORKERS' COMPENSATION INFORMATION
IS EE ENTITLED TO RECEIVE OR HAS THE EE RECEIVED WORKERS' COMPENSATION TEMPORARY DISABILITY OR IDL FOR ANY DAY AFTER THE LAST DAY PHYSICALLY WORKED SHOWN ABOVE? ☐YES ☐NO ☐PENDING
IF YES, PROVIDE PERIODS PAID FROM _____ TO _____.
FOR WHAT BODY PARTS? _____
FOR WHAT DATE OF INJURY? _____
HAS EE RETURNED TO WORK? ☐YES ☐NO
IF YES: ☐PART TIME ☐FULL TIME GIVE DATE(S) _____ _____

**NOTE TO EMPLOYER:**
**While the NDI office determines the period of eligibility and authorizes payment on claims, your personnel office has the responsibility for requesting payment from the State Controller.**

18. CSUS EMPLOYEES ONLY
EE APPOINTED FOR ONE YEAR OF SERVICE OR ONE ACADEMIC YEAR OR MORE? ☐YES ☐NO
ACADEMIC EMPLOYEE? ☐YES ☐NO
IF "YES," SHOW ☐10/10 ☐10/12 ☐12/12
AND THE DESIGNATED SUMMER PERIOD OR QUARTER OFF DATES: _____
IF EE IS RECEIVING CATASTROPHIC LEAVE, IS IT SUPPLEMENTING NDI? ☐YES ☐NO

# Leave of Absence (LOA)/Leave Types *Continue*

## Sample of First Claim for NDI Form – DE 8501 Continue

**NDI Applicant:** Please complete all items below after you have stopped working due to disability.

**Part B - Claim Statement of Employee**

**1. YOUR MAILING ADDRESS**
STREET, P.O. BOX, OR RFD | APT. NO. | CITY | STATE | ZIP CODE

**2. DATE OF BIRTH**

**3. YOUR HOME ADDRESS** (IF DIFFERENT FROM MAILING ADDRESS)

**4. OTHER NAME(S) USED**

**5. OCCUPATION**

**6. WHAT WAS THE FIRST DAY YOU WERE TOO SICK TO WORK,** EVEN IF IT WAS A SATURDAY, SUNDAY, HOLIDAY, OR NORMAL DAY OFF?
MONTH | DAY | YEAR

**7. WHAT WAS THE LAST DAY YOU WORKED BEFORE THIS DISABILITY?**
MONTH | DAY | YEAR

**8. DID YOU STOP WORK BECAUSE OF SICKNESS, INJURY, SURGERY, OR PREGNANCY?** ..... YES ☐ NO
IF "NO," PLEASE EXPLAIN:

**9. WAS THIS DISABILITY OR ANY OTHER DISABILITY DURING THIS CLAIM PERIOD CAUSED BY YOUR WORK?** ..... ☐ YES ☐ NO
HAVE YOU FILED A CLAIM FOR WORKERS' COMPENSATION? ..... ☐ YES ☐ NO
IF "YES," PLEASE PROVIDE THE FOLLOWING INFORMATION:

| NAME OF WORKERS' COMPENSATION INSURANCE CARRIER | | CARRIER'S TELEPHONE NUMBER ( ) |
|---|---|---|
| ADDRESS OF CARRIER | | |
| NAME OF ADJUSTER | DATE OF INJURY / / | CLAIM NUMBER |
| BODY PART(S) | | |
| ARE YOU RECEIVING WORKER'S COMPENSATION BENEFITS? ☐ YES ☐ NO | IF "YES," BENEFITS PAID FROM ____ TO ____ | |

**10. IF ANNUAL LEAVE PARTICIPANT, INDICATE YOUR DESIRE TO SUPPLEMENT NDI WITH LEAVE** ..... ☐ NO SUPPLEMENT ☐ 75% ☐ 100%

**11. HAVE YOU RECOVERED FROM YOUR DISABILITY?** ..... ☐ YES ☐ NO
IF "YES," PLEASE ENTER DATE ____

**12. HAVE YOU RETURNED TO WORK AFTER THE DATE SHOWN ABOVE IN ITEM 6?** ..... ☐ YES ☐ NO
IF "YES," PLEASE ENTER DATE(S) ____ ☐ FULL-TIME ☐ PART-TIME

**PLEASE REVIEW, SIGN, AND DATE BOTH No. 13 AND No. 14.**

**13. Health Insurance Portability and Accountability Act Authorization.** I authorize any physician, practitioner, hospital, vocational rehabilitation counselor, or workers' compensation insurance carrier to furnish and disclose to employees of California Employment Development Department (EDD) all facts concerning my disability that are under their control. I understand that EDD may disclose information as authorized by the California Unemployment Insurance Code and that such redisclosed information may no longer be protected by this rule. I agree that photocopies of this authorization shall be as valid as the original. I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled. (A large-print version of this text is contained on page 4 of this form.)

| YOUR SIGNATURE (DO NOT PRINT) | DATE SIGNED |
|---|---|
| | |

**14. Declaration and Signature.** I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled and that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize my employer to furnish and disclose all facts concerning my disability and wages or earnings that are within his/her knowledge. I understand this authorization is granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as the original.

| YOUR SIGNATURE (DO NOT PRINT) | DATE SIGNED | WORK TELEPHONE NUMBER ( ) | HOME TELEPHONE NUMBER ( ) |
|---|---|---|---|
| | | | |

**15. Personal Representative** signing on behalf of claimant must complete the following: I, ____, represent the claimant in this matter as authorized by ☐ power of attorney (attach copy) ☐ Declaration of Individual Claiming Disability Insurance Benefits Due an Incapacitated or Deceased Claimant, DE 2522 (see pg. A,#4)

| Personal Representative's Signature (DO NOT PRINT) | Date Signed |
|---|---|
| | |

**IT IS A VIOLATION OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE TO WILLFULLY MAKE A FALSE STATEMENT OR TO KNOWINGLY CONCEAL A MATERIAL FACT IN ORDER TO OBTAIN THE PAYMENT OF ANY BENEFITS.**

**NOTE TO NDI CLAIMANT: The NDI office determines the period of eligibility and authorizes payment on claims, but your employer's personnel office has the responsibility for requesting payment from the State Controller. Please contact your employer's personnel office if you have any questions regarding payments.**

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

## Sample of First Claim for NDI Form – DE 8501 Continue

**Part C - Doctor's Certificate**

Certification may be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States Government facility. Certification may also be made by a licensed nurse-midwife, nurse practitioner, or licensed midwife for disabilities related to normal pregnancy or childbirth. **All items on this sheet must be completed legibly.**

| PATIENT FILE OR ID NO. | PATIENT'S NAME | PATIENT'S SOCIAL SECURITY NUMBER |
|---|---|---|
| | | |

**16. I ATTENDED THIS PATIENT FOR THE PRESENT MEDICAL PROBLEM**
FROM / / (MM DD YY) TO / / (MM DD YY) AT INTERVALS OF ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ AS NEEDED

**17. HISTORY:**

**18. OBJECTIVE FINDINGS / DETAILED STATEMENT OF SYMPTOMS:**

**19. DIAGNOSIS:**

SAMPLE

**20. ICD CODE PRIMARY** (REQUIRED):

**21. ICD CODE SECONDARY:**

**22. TYPE OF TREATMENT AND/OR MEDICATION RENDERED TO PATIENT:**

**23. REFERRED TO** (E.G., SPECIALIST, PT, COUNSELING):

**24A. IF THIS PATIENT IS NOW OR WAS PREGNANT SINCE THE DATE OF TREATMENT REPORTED ABOVE, PLEASE PROVIDE FUTURE EDC OR DATE PREGNANCY TERMINATED:**

**24B. IF PREGNANCY IS/WAS ABNORMAL, STATE THE ABNORMAL AND INVOLUNTARY COMPLICATION CAUSING MATERNAL DISABILITY:**

**25A. IF HOSPITALIZED, IN WHAT HOSPITAL WAS OR IS PATIENT CONFINED AS A REGISTERED BED PATIENT?**
NAME OF FACILITY
ADDRESS
DATE ENTERED / / DATE DISCHARGED / /

**25B. IF TREATED IN A SURGICAL CLINIC, IN WHAT SURGICAL CLINIC WAS PATIENT TREATED?**
NAME
DATE ENTERED / / DATE DISCHARGED / /

**26. WAS ABOVE HOSPITALIZATION FOR A SURGICAL PROCEDURE?** ☐ YES ☐ NO
IF "YES," PLEASE DESCRIBE TYPE: _____ DATE PERFORMED/TO BE PERFORMED: / / ICD CODE (REQUIRED) _____
IF "NO," STATE THE PURPOSE FOR CONFINEMENT: _____ CPT PROCEDURE CODE C

**27. AT ANY TIME DURING YOUR ATTENDANCE, HAS THIS PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR WORK?** ☐ YES ☐ NO
IF "YES," ON WHAT DATE DID DISABILITY COMMENCE? / / (REQUIRED)

**28. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK.** THIS IS A REQUIREMENT OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE, AND THE CLAIM WILL BE DELAYED IF NO DATE IS ENTERED. ANSWERS SUCH AS "INDEFINITE" OR "UNKNOWN" ARE NOT ACCEPTABLE. / /

**29. WORKERS' COMPENSATION INFORMATION**
A. IN YOUR OPINION, IS THIS DISABILITY THE RESULT OF "OCCUPATION," EITHER AS AN "INDUSTRIAL ACCIDENT" OR AS AN OCCUPATIONAL DISEASE? ☐ YES ☐ NO
(THIS SHOULD INCLUDE AGGRAVATION OF PRE-EXISTING CONDITIONS BY OCCUPATION.)
B. HAVE YOU REPORTED THIS OR A CONCURRENT DISABILITY TO ANY INSURANCE CARRIER AS AN INDUSTRIAL DISABILITY LEAVE OR WORKERS' COMPENSATION CLAIM? ☐ YES ☐ NO
C. IF "YES," GIVE NAME OF CARRIER OR FIRM: _____

**30. DRUG- AND ALCOHOL-RELATED CLAIMS**
A. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF REFERRAL OR RECOMMENDATION TO AN ALCOHOLIC RECOVERY HOME OR DRUG-FREE RESIDENTIAL FACILITY? ☐ YES ☐ NO
B. IF "YES," PLEASE PROVIDE: FACILITY NAME: _____ TELEPHONE NUMBER: ( )
ADDRESS: _____ DATE ENTERED: / / DATE DISCHARGED: / /
C. IS THIS PATIENT UNDER YOUR DIRECT MEDICAL CARE? ☐ YES ☐ NO

**31. FURTHER COMMENTS** (IF INDICATED)

**32. WOULD DISCLOSURE OF THIS INFORMATION TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL?** ☐ YES ☐ NO

**Doctor's Certification and Signature (Required): Having considered the patient's regular or customary work, I certify under penalty of perjury that, based on my examination, the foregoing Doctor's Certificate truly describes the patient's disability (if any) and the estimated duration thereof.**

**I further certify that I am a** _____ (Type of Doctor) _____ (Specialty, if any) **licensed to practice by the State of** _____

_____ (Print or type Doctor's Name)

_____ (Original signature of Attending Doctor) **Rubber Stamp is Not Acceptable.**

No. and Street | City | State | ZIP Code | State License No. | Telephone No. | Date Signed

Under sections 2116 through 2117.5 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000.

# Leave of Absence (LOA)/Leave Types *Continue*

## Sample of Employee's Claim - Form SCIF 3301

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

*Estado de California*
*Departamento de Relaciones Industriales*
*DIVISION DE COMPENSACIÓN AL TRABAJADOR*

**WORKERS' COMPENSATION CLAIM FORM (DWC 1)**

***PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)***

**Employee:** Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

***Empleado:*** *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.*

*Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.*

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

**Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".**

**Employee—complete this section and see note above** ***Empleado—complete esta sección y note la notación arriba.***

SAMPLE

1. Name. *Nombre.* _____ Date of Birth. *Fecha de Nacimiento.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurrió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

**Employer—complete this section and see note below.** ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.*
    State Compensation Insurance Fund
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

**Employer:** You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

***Empleador:*** *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

*EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD*

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

e3301 (Rev. 9/10) - DWC Form 1 (Rev. 6/10)

# Leave of Absence (LOA)/Leave Types *Continue*

## Sample of Employee's Claim - Form SCIF 3067

**State of California**

**EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS**

**STATE COMPENSATION INSURANCE FUND**
24-Hour Claims Reporting Center
Telephone: (888) 222-3211 Fax (800) 371-5905

**OSHA Case No.**

☐ Fatality

**Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.**

NOTICE: California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

**EMPLOYER**

1. FIRM NAME — DIVISION — 1a. Policy Number — Please do not use this Column
2. MAILING ADDRESS (Number and Street, City, Zip) — 2a. Phone Number — Case Number
3. LOCATION, if different from Mailing Address (Number, Street, City and Zip) — 3a. Location Code — Ownership
4. NATURE OF BUSINESS; e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO. — Industry
6. TYPE OF EMPLOYER — Occupation
☐ PRIVATE ☐ STATE ☐ COUNTY ☐ CITY ☐ SCHOOL ☐ OTHER GOVERNMENT SPECIFY _____

**INJURY OR ILLNESS**

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy) — Sex
8. TIME INJURY/ILLNESS OCCURRED _____ A.M. _____ P.M. — 9. TIME EMPLOYEE BEGAN WORK _____ A.M. _____ P.M. — 10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO — 12. DATE LAST WORKED (mm/dd/yy) — 13. DATE RETURNED TO WORK (mm/dd/yy) — 14. IF STILL OFF WORK, CHECK THIS BOX ☐ — Age
15. PAID FULL DAY'S WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ YES ☐ NO — 16. SALARY BEING CONTINUED? ☐ YES ☐ NO — 17. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm/dd/yy) — 18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy) — Daily hours
19. SPECIFIC INJURY/ILLNESS AND MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning — 19a. BODY PART AFFECTED — Days per Week
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Address) — 20a. ZIP — 20b. COUNTY — 21. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO — 21a. WAS ANOTHER PERSON RESPONSIBLE? ☐ YES ☐ NO — Weekly Hours
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop. — 23. OTHER WORKERS INJURED OR ILL IN THIS EVENT? ☐ YES ☐ NO — Weekly Wage
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold.
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck. — County
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY. — Nature of Injury
27. NAME AND ADDRESS OF PHYSICIAN (Number, Street, City, Zip) — 27a. Phone Number
28. HOSPITALIZED AS AN INPATIENT OVERNIGHT? ☐ NO ☐ YES If yes, then, NAME AND ADDRESS OF HOSPITAL (Number, Street, City, Zip) — 28a. Phone Number — Part of body
29. Employee treated in Emergency Room? ☐ YES ☐ NO

**ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.**
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2.* — Source

**EMPLOYEE**

30. EMPLOYEE NAME — 31. SOCIAL SECURITY NUMBER — 32. DATE OF BIRTH (mm/dd/yy) — Event
33. HOME ADDRESS (Number, Street, City, Zip) — 33a. PHONE NUMBER
34. SEX ☐ MALE ☐ FEMALE — 35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers) — 36. DATE OF HIRE (mm/dd/yy) — Secondary Source
37. EMPLOYEE USUALLY WORKS _____ hours per day _____ days per week _____ total weekly hours — 37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal ☐ disabled ☐ retired ☐ laid-off ☐ unemployed ☐ on strike ☐ other — 37b. UNDER WHAT CLASS CODE OF YOUR POLICY WERE WAGES ASSIGNED? — Extent of Injury
38. GROSS WAGES/SALARY $ _____ per _____ — 39. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, overtime, bonuses, etc.)? ☐ YES ☐ NO

40. Number of employees on most recent policy inception or renewal date in effect at time of injury. — Date (mm/dd/yy)

Completed By (type or print) — Signature & Title

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

SCIF e3067 (REV. 9-07)

**FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. A CLAIM FORM MUST BE GIVEN TO THE INJURED WORKER WITHIN ONE WORKING DAY OF YOUR KNOWLEDGE OF OCCUPATIONAL INJURY OR ILLNESS WHICH RESULTS IN LOST TIME OR MEDICAL TREATMENT.**

SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

**State Disability Insurance Program**

**State Disability Insurance (SDI)**

California State Disability Insurance (SDI) is a partial wage-replacement insurance plan for California workers. The SDI programs are State mandated and funded through employee payroll deductions. Workers covered by SDI are covered by two programs: Disability Insurance and Paid Family Leave.

The **Disability Insurance (DI)** program provides affordable, short-term benefits to eligible workers who suffer a loss of wages when they are unable to work due to a non-work related illness or injury, or due to pregnancy or childbirth.

The **Paid Family Leave (PFL)** program was established for workers who suffer a loss of wages when they need to take time off from work to care for a seriously ill child, spouse, parent, registered domestic partner, or to bond with a new child.

**Important** - The Notice to Employer of State Disability Claim Filed (Form DE2503) must be completed and verified by the employee's assigned DTU Specialist and returned to EDD within two working days. **Failure to respond to the DE2503 may delay or disqualify SDI benefits**.

**Who Is Eligible**
Civil service rank and file employees in Bargaining units R01, R03, R04, R11, R14, R15, R17, R20, R21, E01, E03, E04, E11, E14, E15, E17, E20, and E21 are subject to mandatory SDI withholding. Retired annuitants are excluded from SDI withholding.

# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

### Attendance Clerk

When employees notify you of their intent to file for SDI benefits, follow the below procedures to ensure timely processing of their SDI claim.

Notify your DTU Specialist once you have been informed by the employee is filing for SDI. Provide the employee with the SDI/PFL Packet DTU will send you. The packet contains the following documents:

- SDI/PFL Employee Responsibilities
- SDI Supervisor Checklist
- Employee SDI Reference Guide

*and the below documents may be accessed via these links:*

- Formal Leave of Absence Request (DGS OHR 28)
- DE 2501 - Claim for Disability Insurance Benefits
- CalHR 752 - Notice of Eligibility
- CalHR 753 - Designation Notice
- CalHR 754 Certification of Health Care Provider (Self)
- CalHR 755 - Certification of Health Care Provider (Family Member)

- AC verifies leave balance with Personnel Transactions Specialist
- AC provides employee with the State Disability Insurance Employee Options Checklist accessed at: http://www.documents.dgs.ca.gov/ohr/sdi/SDI eeoptionschklst.doc
- Once the employees' last day of work or last day on pay status has been verified, notify the assigned Personnel Specialist **immediately** to avoid any overpayments
- Notify employees of their FMLA rights and direct them to our FMLA Clerk
- Ensure that employees submit their absence plan to their supervisor for approval prior to their last day of work
- While the disability claim is pending approval and if necessary, assist the employees in completing their time entry in PAL or the STD 634s for Boards and Commissions
- In the employee's absence while their disability claim is pending approval, enter leave usage and/or dock in PAL or on the STD 634s for Boards and Commissions. Submit these timely to the supervisors for approval prior to cut-off

  ***Important!*** If the employee is working while on SDI, timesheets must be completed accurately and submitted timely to the DTU specialist to request pay to issue.
- If necessary, assist employees in completing the DE 2501 to initiate their disability claim

  ***Note:*** *A listing of forms to be completed for the corresponding leave type is identified in this manual section.*
- Refer employees to their assigned Disability Transactions Unit (DTU) Specialist or for additional information, FAQs and to obtain/download applications, to the EDD website via this link: http://www.edd.ca.gov/Disability/

# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

### Attendance Clerk Continued

- **Immediately** notify the assigned DTU specialist of the employees return to work date including any restrictions or modified duties

- Employees **must** provide a medical release to their supervisor upon their return to work

- Any questions regarding the employee's return to work date must be directed to the assigned DTU specialist

  ***Important!*** *The Employment Development Department (EDD) does not provide the employees' disability dates to the DTU Specialists. This information can only be obtained by the employees themselves.*

  If AC receives claim form, s/he immediately forwards it to his/her Personnel Transactions Specialist (DO NOT COMPLETE).

# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

### Sample of SDI/PFL Employee Responsibilities Checklist

**STATE DISABILITY INSURANCE (SDI) / PAID FAMILY LEAVE (PFL)**
**EMPLOYEE RESPONSIBILITIES CHECKLIST**

SAMPLE

1) Immediately notify your Supervisor (Supv) and Attendance Clerk (AC) of injury, illness or reason for absence.
2) Request the State Disability Insurance (SDI)/Paid Family Leave (PFL) Employee Options Checklist from your Supv/AC and complete, sign, date and return to your Supv/AC.
3) Submit an Absence Plan to your Supv/AC. The Absence Plan identifies the approximate time you will be away from work due to your illness or injury. The Plan must be approved by your supervisor and be in accordance with your bargaining unit contract.
4) Contact EDD via phone call or internet to obtain applications for SDI or PFL
5) EDD – SDI Unit DI for State Employees.
    a. (866) 352-7675 or http://www.edd.ca.gov/Disability/Disability_Insurance.htm
6) EDD – PFL Unit for State Employees.
    a. (877) 238-4374 or http://www.edd.ca.gov/Disability/Paid_Family_Leave.htm
7) Submit DE2501 to doctor or treating physician. The DE2501 can be found at: http://www.edd.ca.gov/pdf_pub_ctr/de2501.pdf. If eligible, submit the FMLA - Medical Certification of Health Care Provider to your physician for completion and return to Supervisor/AC **within 15 calendar days**.
8) Payment verifications must be provided to your Human Resources (HR) Office in order to receive timely leave credit supplementation payment(s).
    a. SDI/PFL Check Stubs
    b. SD/PFLI Notice of Computation from EDD(provides potential award information)
9) It is your responsibility to contact your supervisor to inform her/him of your leave request for disability and/or PFL in a timely manner and in accordance with any written or verbal instructions they may have provided or discussed with you.
10) For SDI provide a Medical Release to your immediate supervisor when returning to work on or before the anticipated effective date of your return.
11) For SDI provide medical substantiation to your immediate supervisor if you are not able to return to work on your anticipated return date. Substantiation for your extended absence must be provided to your immediate supervisor on or before your original anticipated date of return.

I hereby acknowledge receipt of my responsibilities during my absence while on SDI.

| Employee Signature | Date |
|---|---|
| | Home Phone |

**NOTE:** Regardless of medical information provided by you or your doctor to the Employment Development Department for SDI purposes, it is your responsibility to keep your supervisor informed of your absence, including extensions of medical leave. Your supervisor may require you to provide written substantiation from your medical practitioner. **FAILURE TO KEEP YOUR SUPERVISOR INFORMED OF YOUR ABSENCE MAY RESULT IN YOUR BEING MARKED ABSENT WITHOUT LEAVE (AWOL) DURING THE COURSE OF YOUR ABSENCE.** If you are AWOL for five consecutive working days, you may be subject to automatic resignation from State service.

# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

**Sample of Formal Leave of Absence Request**
**Form DGS OHR 28**

CLEAR SAVE

STATE OF CALIFORNIA
**FORMAL LEAVE OF ABSENCE REQUEST**
DGS OHR 28 (Rev. 4/16)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

***See below for additional information and instructions.***

| EMPLOYEE NAME (LAST, FIRST MI) | SOCIAL SECURITY NUMBER (LAST 4) | CBID |
|---|---|---|
| OFFICE/CLIENT AGENCY | POSITION NUMBER | TIME BASE |

SAMPLE

**TO BE COMPLETED BY EMPLOYEE**

REQUEST TYPE

☐ **Initial Request** ☐ **Extension**

I hereby request a formal leave of absence for the following:

☐ Substantiation Attached

PERIOD OF LEAVE OF ABSENCE: FROM: TO:

| *I am aware that I am responsible for the payment of full premiums for any insurance in which I am enrolled.* | EMPLOYEE'S SIGNATURE | DATE |
|---|---|---|

**TO BE COMPLETED BY IMMEDIATE SUPERVISOR**

I RECOMMEND THE REQUEST FOR LEAVE OF ABSENCE BE:

☐ **APPROVED**

☐ **DENIED Explain:**

| PRINT SUPERVISOR'S NAME | SUPERVISOR'S SIGNATURE | DATE |
|---|---|---|

**TO BE COMPLETED BY OFFICE CHIEF OR CLIENT AGENCY EXECUTIVE**

THE REQUEST FOR LEAVE OF ABSENCE IS:

☐ **APPROVED**

☐ **DENIED** *Explain:*

| PRINT SUPERVISOR'S NAME | SUPERVISOR'S SIGNATURE | DATE |
|---|---|---|

**PERSONNEL TRANSACTION UNIT USE ONLY**

| DATE PAR KEYED | COMPLETED BY | DATE |
|---|---|---|

# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

### Sample of SDI/PFL Employee Options Checklist

DGS GENERAL SERVICES

State of California • Government Operations Agency • Edmund G. Brown Jr., Governor

**DEPARTMENT OF GENERAL SERVICES**

**Administration Division Office of Human Resources**

**STATE DISABILITY INSURANCE & PAID FAMILY LEAVE EMPLOYEE OPTIONS CHECKLIST**

(Complete your portion of this form, print, sign and give to your supervisor for signature)

| | |
|---|---|
| **NAME (Last, First MI)** | **CBID:** |
| **SSN (Last Four Digits Only):** **HOME PHONE :** | **ABMS ID:** |

**LEAVE OF ABSENCE**

| | |
|---|---|
| BEGINNING DATE: | ENDING DATE: |

Below is a list of options that are available to you. Please make your election, attach your medical substantiation and return this form no later than seven days from date of disability. Failure to do so may result in the loss of coverage:

SAMPLE

**OPTION A:**
I choose to request a medical leave of absence while on SDI ☐ PFL ☐ (leave due to pregnancy ☐ ) and:

1) ☐ I elect to use my leave credits to cover the seven (7) day SDI/PFL waiting period. Please indicate the leave type and amount of leave you would like to use.
☐ Sick # of hours ☐ Vacation # of hours ☐ PH # of hours ☐ CTO # of hours
☐ Excess # of hours ☐ Holiday Credit # of hours ☐ Other (identify type ) # of hours

2) ☐ I elect to use my leave credits to cover the seven (7) day SDI/PFL waiting period **AND** continue to use leave credits through the following date before electing to receive SDI Benefits.
☐ Sick # of hours ☐ Vacation # of hours ☐ PH # of hours ☐ CTO # of hours
☐ Excess # of hours ☐ Holiday Credit # of hours ☐ Other (identify type ) # of hours
Date leave credits paid through .

3) ☐ I elect to use the following leave credits to supplement my SDI/PFL benefit (max of 40 hours per pay period).
☐ Sick # of hours ☐ Vacation # of hours ☐ PH # of hours ☐ CTO # of hours
☐ Excess # of hours ☐ Holiday Credit # of hours ☐ Other (identify type ) # of hours

*The employee must provide the HR office copies of the following documents to ensure proper leave credit supplementation:*

- *SDI/PFL check stubs*
- *SDI/PFL Notice of Computation from EDD*
- *Notice of Determination from EDD (Must be provided within 7 days)*

**WHEN OPTIONS CHECKLIST IS RECEIVED IN PTU NO CHANGES WILL BE ALLOWED FOR SUPPLEMENTATION**

**OPTION B:**
I choose **NOT** to be on SDI and:
☐ I am requesting a paid leave of absence and I will use leave credits to cover the period from to . (A leave plan is required).

**OPTION C:**
I choose **NOT** to be on SDI and:
☐ I am requesting an unpaid formal leave of absence from to . I am aware that I am fully responsible for the payment of full premiums for any insurance in which I am enrolled.

**HEALTH BENEFITS** ☐ **I elect to continue my health benefits, I understand when I return upon my return or separation I will be responsible for repayment of the employee's portion of the health insurance premium. Initial here _____** ☐ **I choose not to continue my health benefits**

**TO BE COMPLETED BY ATTENDANCE CLERK OR SUPERVISOR**

Leave credits available as of:
Sick Leave Vacation/Annual Leave Personal Holiday PLP/2003, VPLP CTO Excess
Other (Specify type) :

| | |
|---|---|
| **Employee's Signature** _____ **Date:** | **Supervisor's Signature** _____ **Date:** |

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# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

### SDI Supervisor Checklist

STATE DISABILITY INSURANCE (SDI) PAID FAMILY LEAVE (PFL)
CHECKLIST FOR ATTENDANCE CLERK SUPERVISORS

**Employee Name** _____ **Date**_____

Employee's in SEIU-represented Bargaining Units 1, 3, 4, 11, 14, 15, 17, 20, and 21 are eligible for SDI.

SAMPLE

- ☐ Employee gives written notice of an absence for illness, injury, pregnancy or a need to bond or care for a newborn or adopted child.
- ☐ Contact Disability Specialist to verify FMLA eligibility and leave balance.
  - ☐ If eligible, provide employee with FMLA package accessed at http://www.documents.dgs.ca.gov/ohr/Supervisor/DGSFMLAPolicyProcedures.pdf
  - ☐ If not eligible, provide employee with a copy of the first page of appendix D of the FMLA package noting reason for not being eligible.
- ☐ Provide employee with the Employee Options Check List. The employee has an option to use leave credits to cover their SDI absence or to supplement their disability benefit (waiting period included). http://www.documents.dgs.ca.gov/ohr/SDI/SDI EE's Options Checklist.xls
- ☐ Provide employee with copy of the Employee's Responsibilities for SDI. http://www.documents.dgs.ca.gov/ohr/SDI/sdi ee responsibilities.doc
- ☐ Provide employee with a copy of the reference guide to SDI and FMLA "links." http://www.documents.dgs.ca.gov/ohr/SDI/EMPLOYEE SDI REFERENCE GUIDE.doc
- ☐ Provide the Formal Leave of Absence Request form to the employee when the employee's absence will extend beyond the SDI/PFL benefit period. http://www.documents.dgs.ca.gov/ohr/pom/GS28.pdf
- ☐ Request the employee to provide an Absence Plan. Absence Plan will also include the employee's return to work date. The employee is required to provide a medical release before returning to work.
- ☐ Request treating physician substantiation for SDI eligibility.
- ☐ Supervisor or Attendance Clerk insures time is posted in PAL correctly and approved. *(See alias list for PAL)*
- ☐ Supervisor or Attendance Clerk must contact Disability Unit as soon as he/she is aware of what date the employee will be returning to work.
- ☐ If EDD claim form (DE2501) is received, do not complete, immediately forward to Personnel Transactions.
- ☐ Office must immediately notify the DTU when the employee returns to work.
  **NOTE: If you have any questions please contact your Personnel Specialist.**

Rev 11/08

# Leave of Absence (LOA)/Leave Types *Continue*

**State Disability Insurance Program** Continue

**Employees Reference Guide to SDI/PFL Information**

**EMPLOYEE'S REFERENCE GUIDE TO SDI/PFL INFORMATION**

The following "links" are provided to assist you with SDI and PFL information and the filing of your claim.

To file a SDI and/or PFL claim, you may contact EDD at the following:

EDD unit; SDI for State Employees
(866) 352-7675 or www.edd.ca.gov

SDI mailing address:
P.O. Box 2168
Stockton, CA 95201-2168

EDD unit; PFL for State Employees
(877) 238-4373 or www.edd.ca.gov

PFL mailing address:
P.O. Box 997017
Sacramento, CA 95799-7017

Please complete your claim form referencing employer's address as:

DEPARTMENT OF GENERAL SERVICES
P.O. BOX 989052
OFFICE OF HUMAN RESOURCES, 7TH FLOOR
WEST SACRAMENTO, CA 95798-9052
916-376-5457

Your claim could be delayed if this address is not noted on your claim form.

If you do not have computer access to navigate through these "links", please request that your Supervisor print out the information.

# Leave of Absence (LOA)/Leave Types *Continue*

## State Disability Insurance Program Continue

**Sample of Claim for Disability Insurance Benefits**
**Form DE 2501**

EDD Employment Development Department State of California

**Claim for Disability Insurance (DI) Benefits**

250104121

**Health Insurance Portability and Accountability Act (HIPAA) Authorization**

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

| Claimant Signature (Do Not Print) | Date Signed M M D D Y Y Y Y |
|---|---|

DE 2501 Rev. 75 (4-12) Page 1 of 7 CU

# Leave of Absence (LOA)/Leave Types *Continue*

## Non-Industrial Disability Insurance

Non-Industrial Disability Insurance (NDI) covers excluded employees and represented employees in bargaining units 2, 5, 6, 7, 8, 9, 10, 12, 13, 16, 18 and 19. Employees in other units are covered under State Disability Insurance for State Employees.

An employee must be a current active member of the CalPERS, the State Teachers' Retirement System (STRS) or a full-time or part-time State Officer or employee of the Legislature. An employee must be in "compensated employment" (on pay status and not separated by a formal leave of absence).

NDI pays part of your wages should you take a qualified leave, typically due to illness or injury. The State employer pays for NDI, the employee pays nothing.

For twenty six (26) weeks, NDI provides:

- 50% of your gross pay if you are enrolled in the Annual Leave Program
- Up to $ 135.00 per week if you're not

***Note: The employee* may need to exhaust sick leave before NDI commences. Check employee's bargaining unit contract for more information.**

### Annual Leave and NDI

Most enrollees in Annual Leave automatically become eligible for Enhanced Non-Industrial Disability Insurance. NDI is a form of insurance that provides income in case the employee suffers a non-work-related disability and can't work for an extended period.

The chart below shows the advantages of Enhanced NDI over the basic NDI benefit.

| Basic NDI | Enhanced NDI |
|---|---|
| Pays $ 135/week for up to 26 weeks | You receive 50% of your gross salary up to 26 weeks |
| No supplementation | May supplement using leave credits up to 75 % or 100 % of their income level |

# Leave of Absence (LOA)/Leave Types *Continue*

## Non-Industrial Disability Insurance Continue

### Waiting Period

There is a **seven-day** waiting period for the majority of represented and all excluded employees covered by NDI. To determine the waiting period, the appropriate bargaining agreement for the employee should be reviewed. Emergency room care does not constitute hospitalization and will not waive the waiting period.

> ***Important!*** **This waiting period will be waived if the employee is confined in a hospital or nursing home at least one day.**

### Attendance Clerk Responsibilities

When employees notify you of their intent to file for NDI benefits, follow the steps in the table below to ensure timely processing of their NDI claim.

| Action |
|---|
| Supervisor(s) must provide employees with the Benefits Option Package<br><br>***Note:*** **In the supervisors absence, the DTU Specialist will provide the Benefits Options Package to the employee** |
| Verify if employees are eligible for enhanced NDI; if so, inform employees of the benefits of enhanced NDI over the basic NDI |
| Contact assigned PSS to verify employees' leave balance |
| Notify employees of their FMLA rights and direct them to the FMLA Clerk for eligibility verification |
| Assist employee(s) in completing sections A and B on DE 8501 to initiate their disability claim. Section C is completed by the medical provider |
| If necessary, assist employees in completing health and/or dental forms to initiate any changes in coverage |
| Verify that employees time is accurately entered in PAL |
| If necessary, assist employees in completing their time entry in PAL or STD 634 for Boards and Commissions |
| In the employees absence, enter leave usage and/or dock entry in PAL or complete the STD 634 for Boards and Commissions and submit for their supervisor's approval<br><br>***Important!*** **If the employee is working while on NDI, timesheets must be completed accurately and submitted timely to the DTU Specialist for pay to issue.** |

# Leave of Absence (LOA)/Leave Types *Continue*

## Non-Industrial Disability Insurance Continue

### Attendance Clerk Responsibilities Continue

| Action |
|---|
| If applicable, coordinate CAT or Family leave donations with the DTU Specialist |
| Ensure that employees submit their absence plan with their supervisor's approval and other forms required to initiate their claim, as applicable |
| Refer employees to their assigned DTU specialist or for additional information or FAQs, to the EDD website via this link:<br>EDD - Disability Insurance |
| Notify the assigned DTU Specialist of employee's return to work date, if known, including any restrictions or modified duties |
| If applicable, ensure that employees provide a medical release upon their return to work |
| If the return to work date is unknown, the AC **must** contact their assigned DTU Specialist to confirm the employees disability end date |
| Refer to the link below to access the NDI - Employee, Attendance Clerk and Supervisor's Responsibilities<br>NDI- Employee/AC/Supervisor Responsibilities |

# Leave of Absence (LOA)/Leave Types *Continue*

## **Non-Industrial Disability Insurance** Continue

To ensure timely processing of employee's NDI claim, all Attendance Clerks must use the NDI Disability Leave checklist which is included in the Benefits Options Package sent to you by the Disability Unit.

### Sample of NDI Employee/AC/Supervisor Responsibilities (Front)

**NON-INDUSTRIAL DISABILITY LEAVE**

**EMPLOYEE RESPONSIBILITIES**

- Notify Attendance/Clerk (AC) and/or Supervisor (Sup) of injury or illness.
- Request verification from Sup/AC of leave balance and eligibility notice of FMLA/CFRA Leave.
- Request DE8501 (NDI application) from AC and complete employee portion (part B) with the A/C. AC will complete part A and submit a copy to the Disability Unit.
- Retain a copy for your records.
- Submit original DE8501 to physician or medical provider for completion of part C. Physician or medical provider will mail the entire form to EDD.
- Upon receipt of Benefit Options package, review and make a selection to:
  1) enroll in annual leave to receive Enhanced NDI (50%, 75%, 100% income replacement)
  2) or decline and receive NDI daily rate of $19.29.
- Submit completed Benefit Options package to Sup/AC.
- Discuss your anticipated time off with your Supervisor or A/C
- Provide the (FMLA) Medical Certification of Health Care Provider (if eligible) to doctor for completion. Return completed form to Supervisor or A/C within 15 days.
- Submit "Physician Medical Extension (EDD) to doctor to insure continuation of NDI benefits without interruption.
- You are responsible for personally contacting your supervisor to inform him/her of your status on a timely basis and in accordance with any written or verbal instructions he/her may have provided to you.
- Obtain a written medical release from doctor prior to returning to work.
- If you are released to return to work, with or without restrictions, a medical release must be provided to your supervisor upon your return.
- If you are not released to return to work, you must provide your supervisor with appropriate medical substantiation for your extended absence on or before the anticipated date of return.
- It is important that contact be made as soon as possible so not affect the NDI benefit. Failure to do so may result in loss of coverage as well as your absence reported as AWOL

I hereby acknowledge receipt of my responsibilities during my absence while on NDI

| Employee Signature | Date |
|---|---|
| | Home Phone |

(NOTE: Regardless of the medical information provided to EDD by you or your doctor for NDI purposes, you are responsible to keep your supervisor informed of your absence, including extensions of medical leave. You are required to provide written substantiation from your medical practitioner. **FAILURE TO KEEP YOUR SUPERVISOR INFORMED OF YOUR ABSENCE MAY RESULT IN YOUR BEING MARKED ABSENT WITHOUT LEAVE (AWOL) DURING THE COURSE OF YOUR ABSENCE.** If you are AWOL for five consecutive working days, you may be subject to automatic resignation from State service.)

**Benefit Options Package shall include:**

DE-8501 (NDI application)
Annual Leave Election
Enhanced NDI Supplementation
List of Leave Aliases to post PAL
STD-634's (Boards and Commissions
Notice of Employee's Responsibility
Written Absence Plan
FMLA/CFRA package

| TO BE COMPLETED BY ATTENDANCE CLERK OR SUPERVISOR | |
|---|---|
| Leave Credits Available as of:_____ | |
| Sick Leave_____ | Vacation/Annual Leave:_____ |
| Personal Holiday_____ | PLP/2003, VPLP_____ |
| CTO _____ | Excess _____ |
| Other (Specify) | |

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SAMPLE

# Leave of Absence (LOA)/Leave Types *Continue*

## Non-Industrial Disability Insurance Continue

### Sample of NDI Employee/AC/Supervisor Responsibilities (Back)

**NON-INDUSTRIAL DISABILITY LEAVE**

**Supervisor or Attendance Clerk**

- Receive notice from employee of an injury or illness requiring absence from work.
- Provide employee with Benefits Option Package as applicable.
- Verify if employee is eligible for NDI or SDI.
- Contact Personnel Specialist to verify leave balance and verify FMLA/CFRA eligibility.
- Verify if employee is eligible for enhance NDI. If the employee is eligible for enhanced NDI:
  1) Provide the employee with the option of enrolling in annual leave or to receive traditional NDI.
  2) Employee must complete Annual Leave – Sick Leave/Vacation Election Form to participate in the Annual Leave Program.

  (The effective date of the election shall be the first day of the pay period in which the election form is received by the supervisor).
- Complete part A and B of NDI application (DE 8501), retain one copy for employee and forward one copy to the Disability Transaction Unit.
- Complete Notice of FMLA eligibility (appendix D) and provide to employee. Establish an approximate end date of FMLA.
- Receive absence plan from employee, approved by Supervisor (written absence plan, PAL/STD-634, Enhanced NDI Election, Annual Leave Election, Leave of Absence, CAT-Lv, or FAM-Lv request).
- Verify PAL/634 is posted correctly.
- Forward any CAT/Lv or FAM/Lv donations to Personnel Specialist or DTU.
- Coordinate (CAT/Lv) or (FAM/Lv) donations with DTU specialist.
- Will notify employee of existing leave balance so preparations can be made once the leave balance has been exhausted.
- Forward any forms requesting changes in health (HBD-12), dental (STD-692) or home address (EAR) to Personnel Specialist.
- Receive FMLA from employee and forwards the original to PSS/DTU.
- Provide employee with copy of leave credit restoral.
- Provide copies of any medical extensions to DTU.
- All warrants or Direct Deposits should be released to the employee unless you have any questions or concerns, contact DTU immediately.
- Notifies DTU when the employee has returned to work and if employee is returning to work with restrictions, modified duty or full release.

**Benefit Options Package shall include**:

DE-8501 (NDI application)
Annual Leave Election
Enhanced NDI Supplementation
Notice of Employee's Responsibility
List of Leave Aliases to post PAL**
STD-634's
Absence Plan
FMLA/CFRA (appendix C & D)

SAMPLE

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# Leave of Absence (LOA)/Leave Types *Continue*

## Workers' Compensation

The Workers' Compensation (WC) Program is a no-fault system that provides assured and fixed benefits to State employees injured on the job or become ill due to their jobs.

The WC Program provides compensation to employees for work-related injuries or illnesses, including medical treatment, temporary payment of lost wages, and permanent disability payments.

All State employees are covered by workers' compensation.

The cost of this protection is completely paid by the State of California. The employees make no contribution. Benefits are tax-free and not subject to Social Security deductions.

The first 24-hour period (3 working days) following an employee's date of injury is called a "waiting period." During the waiting period, the employee must use leave credits or dock to supplement the time.

### Waiting Period

There are some important facts about the waiting period:

- The waiting period is waived if the employee is hospitalized or off work more than 14 calendar days
- For IDL purposes, the waiting period must be 24 hours and can be counted in hourly increments
- It is possible to have lost time 14 calendar days from work and not have met the 24-hour waiting period
- If the employee does not miss more than 24-hours (3 working days) of work after the date of injury, leave credits will not be restored.

### RTW Clerks Responsibilities

The Return to Work Clerk (RTW) in OHR is responsible for assisting employees with the workers' compensation process. The Clerk assists DGS employees who have sustained work- related injuries or illnesses; assists management staff with the administration of the workers' compensation process; and monitors workers' compensation cases with the objective of returning injured employees to work as soon as possible.

# Leave of Absence (LOA)/Leave Types *Continue*

**Workers' Compensation** Continue

**Employee Responsibilities**

All DGS employees are expected to:

- Follow safe and healthy workplace practices
- Obtain appropriate first aid and/or call for authorized medical personnel
- Report any workplace injury/illness to their supervisor within 24 hours of the incident

| **If the …** | **Then…** |
|---|---|
| Employee experiences an injury/illness at work that does not require medical treatment beyond first aid AND without loss of time from work | Report the injury/illness to his/her supervisor within 24 hours of the incident<br>▪ Complete employee's portion (lines 1-8) of Employee's Claim for Workers' Compensation Benefits form SCIF e3301<br>▪ Deliver the completed SCIF 3301 to his/her supervisor within 24 hours |
| Employee experiences an injury or illness at work that results in lost time beyond the date of injury and/or results in medical treatment beyond first aid | ▪ Report the injury/illness to his/her supervisor within 24 hours of the incident<br>▪ Complete employee's portion (lines 1-8) of Employee's Claim for Workers' Compensation Benefits form SCIF e3301<br>▪ Deliver the completed SCIF 3301 to his/her supervisor within 24 hours of knowledge of injury<br>▪ Provide the supervisor with all the medical documentation relating to the injury/illness<br>▪ Properly document absences in PAL or STD 634 attributed to workers' compensation |
| Employee is unable to return to regular r/full duty | ▪ The medical substantiation must specifically identify any work limitations and provided to the RTW Clerk |
| Employee is able to return to modified/alternate work | ▪ Contact his/her supervisor immediately to discuss possible modified/alternate work |

# Leave of Absence (LOA)/Leave Types *Continue*

## Workers' Compensation Continue

### Attendance Clerks Responsibilities

When an employee notifies you (the program) of a work-related injury and his/her intent to file for workers' compensation benefits, refer to the steps in the table below to ensure timely processing of his/her claim.

| Action |
|---|
| **Within 24 hours** of receiving notice or knowledge of an injury or illness, provide employees personally or by first-class mail, an Employee Claim Form (SCIF 3301). You may also provide the employee with the I've Just Been Injured on the Job, What Happens Now? Publication (located on CalHR website) |
| Employees **must** acknowledge receipt of the SCIF 3301 by signing the Acknowledgment of Receipt form<br>***Important!*** **You cannot require the employee to complete the SCIF 3301 if they elect not to. However, you must ask them to sign the Acknowledgment Receipt of the SCIF 3301** |
| If the employee is unavailable, the Supervisor(s) must complete the bottom section of the Acknowledgment Form certifying the date the SCIF 3301 was sent via 'certified mail' |
| Within one day after an employee files a claim form, the law requires the employer to authorize medical treatment as required and limited by law, until the claim is accepted or rejected |
| When the employee returns the completed SCIF 3301, give the employee the copy marked "Employee's Temporary Receipt" and then complete the employer's section |
| Once you (supervisor) have completed the form, provide a copy to the employee within one working day of receipt of the form and forward the remaining forms to the RTW Clerk |
| Within 24 hours of notice or knowledge of an injury or illness, supervisor must complete form SCIF e3067 Employers Report of Occupational Injury or Illness via entry into ABMS Injury Report |
| Once report is entered into ABMS, an alert is generated to the Return to Work (RTW) Clerk and the assigned DTU Specialist |
| The RTW Clerk will communicate all questions and/or forward all correspondence regarding the employee's injury to the employee's supervisor (not the employee) |
| Any questions regarding the employee's time entry in PAL will be directed to the assigned DTU Specialist |
| If the return to work date is unknown, the AC **must** contact their assigned DTU Specialist to confirm the employees disability end date |
| Employees' leave restorations will be processed by the DTU Specialists. Any questions regarding this matter may be directed to your assigned DTU Specialist |

# Leave of Absence (LOA)/Leave Types *Continue*

**Workers' Compensation** Continue

***Important!* In the event of an on-the-job injury, supervisors must ensure employees receive prompt and proper medical care, if such care is believed necessary by either the supervisor or the employee***.*

***Who can you contact if you have additional questions or concerns?***

- Your department's Return to Work Clerk
- Your State Fund claims adjuster
- The Department of Industrial Relations, Division of Workers' Compensation web site: www.dir.ca.gov/dwc/InjuredWorker.htm

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# Civil Service Employee Benefits

The California Department of Human Resources (CalHR) is responsible for administering many benefits for state employees. In the following sections you will find basic information regarding most benefits available to state employees. Detailed benefit information can be found on the CalHR website. The California Public Employees' Retirement System (CalPERS) administers most retirement and all health plans for state employees.

This part contains the following topics:


| Topic | See Page |
|---|---|
| CalHR New Employee Benefits Orientation | 201 |
| Essential Benefits | 201 |
| Optional Benefits and Services | 203 |
| Automatic Benefits | 204 |
| Open Enrollment | 204 |


## CalHR New Employee Benefits Orientation

CalHR's website provides the New Employee Benefits Orientation, an interactive resource designed to allow employees to read about Benefits and Services and research Informational Topics related to their State job. The resource provides employees a checklist to ensure all benefits are reviewed by the employee.

Additionally the CalHR and CalPERS websites are the best resources to use when providing employees with benefits information.

### Essential Benefits

The Essential Benefits category is considered the highest priority for new employees. Active employees who work at least half-time or greater with an appointment of six months and one day are eligible for Health Benefits or an appointment of six months or more are eligible for dental, vision and FlexElect benefits; eligibility details for Permanent Intermittent (PI) employees is provided in the Health and Dental Benefits Section of this manual.

Eligible employees have ***60 calendar days*** from the date of appointment or a qualifying event to enroll, add or delete dependents, and make qualifying changes in a health plan, or may do so during an Open Enrollment period.

# Civil Service Employee Benefits *Continue*

**Essential Benefits *Continue***

| Benefit | Administered by | Enrollment |
|---|---|---|
| Health | CalPERS | Form Submitted to Personnel |
| Dental | CalHR | Form Submitted to Personnel |
| Vision Care Program | CalHR | Automatic (exception, PI must enroll) |
| Consolidated Benefits (CoBen) and CoBen Cash Option | CalHR | Form Submitted to Personnel |
| FlexElect Cash Option, Medical and Dependent Care Accounts | CalHR | Form Submitted to Personnel |
| Beneficiary Designation (PERS-BSD 241) | CalPERS | Form Submitted to CalPERS |
| Employee Action Request (EAR) (STD 686) | CalHR | Form Submitted to Personnel |

There are other documents that may be **required** for newly-hired employees and must be submitted to personnel, such as:

- Medical Provider Network
- Military Service Declaration
- Oath of Allegiance
- Employment Eligibility Verification Form I-9 (Required by Federal Law)
- Race/Ethnicity Questionnaire (voluntary)
- Disability Questionnaire (online submission)
- Electronic Communication and Software Policy User Consent Form (typically relates to computer use and communication)
- Emergency Contact Information Form
- Incompatible Activity Statement (forbidden activity)
- Sexual Harassment Information Form

For more information on these documents refer to **"Appointments"** in the Attendance Clerk Manual.

# Civil Service Employee Benefits *Continue*

### Optional Benefits and Services

The second level of benefits to be considered by employees are the optional benefits, however, based on the employees' needs, they may be as important as the essential benefits for many employees. These benefits need to be reviewed by eligible employees to allow them the opportunity to participate in those benefits if desired.

| Benefit | Administered by | Enrollment |
|---|---|---|
| Savings Plus (401(k) and 457) | CalHR | Online enrollment by employee |
| ScholarShare College Savings Plan | | Employee enrollment online through the ScholarShare program |
| Direct Deposit (STD 699) | SCO | Form Submitted to Personnel<br>• Employees are required to have/maintain a minimum leave balance to enroll in the Direct Deposit Program. See HR Memo 11-26 http://www.dgs.ca.gov/ohr/Resources/HRPolicyMemos.aspx |
| Pre-Tax Parking (Cal-HR 682) | CalHR | Form submitted through Parking administrator or Personnel (form used is based on Pre-Tax Program offered) |
| Annual Leave (CalHR 875) | CalHR | Election document submitted to Personnel |
| Long Term Disability (LTD) Ins. (Excluded Employees Only)<br><br>https://www.standard.com/mybenefits/california/ | CalHR | Form submitted to Personnel |
| Long-Term Care Program (Enrollment is Temporarily Closed) | CalPERS | If you are enrolled in the CalPERS Long-Term Care Program and have premiums deducted from your paycheck, you will need to call the Program's Customer Service line at (800) 982-1775 to find out how to continue payment of your premiums after retirement. |
| Consolidated Omnibus Budget Reconciliation Act (COBRA) | Personnel Office | Forms submitted to Personnel |
| Group Legal Services Insurance Plan | CalHR | Form submitted to Personnel<br>• During Open Enrollment (March-April).<br>• Newly eligible employees have 60 calendar days from their effective date of hire/eligibility. |
| Safe at Home-Address Protection | California Secretary of State | Refer to the following website: Safe at Home Welcome - California Secretary of State http://www.sos.ca.gov/safeathome/ |
| Request Non-Disclosure of Home Address (STD 677) | | Form submitted to Personnel |
| Designation of Person to Receive Warrants (STD 243) | | Form Submitted to Personnel with appointment documents |
| The Work Number Employment and Income Verification | CalHR | Call 1-800-EMP-AUTH (1-800-367-2884) or contact Personnel |
| Variable Work Schedule or Alternate Work Schedule (AWS) | DGS | Contact your supervisor |
| Authorization to Use a Privately-Owned Vehicle on State Business (STD 261) | DGS | Contact your supervisor |
| Voluntary Personal Leave Program (Specific Bargaining Units) | CalHR/DGS | Form Submitted to Personnel |

# Civil Service Employee Benefits *Continue*

**Automatic Benefits and Available Services**

The third levels of benefits to be reviewed are Automatic Benefits and Services. These benefits either take effect automatically or are available depending on the need of the employee.

- Paychecks
- CalPERS Retirement
- Alternate Retirement Program
- Part-time, Seasonal and Temporary Program (PST)
- Employee Assistance Program (EAP)
- Sick Leave
- Family Medical Leave
- Bereavement Leave
- Catastrophic Leave
- Vacation Leave
- Military Leave
- State Holidays and Personal Holiday
- Worker's Compensation – Industrial Disability Leave (IDL)
- Non-Industrial Disability Insurance (NDI)
- State Disability Insurance (Specific Bargaining Units)
- Basic Group Life Insurance (Excluded Employees Only)
- Travel and Accident Insurance (Excluded Employees Only)
- Jury Duty

The final level of information provided in the new Employee Orientation includes various topics for employees to review.

**Open Enrollment**

Open enrollment periods are scheduled annually for various benefits during the year. Departments will be notified of open enrollment procedures prior to each open enrollment period. Eligible employees may enroll in a plan, change plans, and/or add/delete dependents during an open enrollment period.

The following benefits hold annual open enrollment periods during the year:

- ✓ Health Benefits
- ✓ Dental Benefits
- ✓ Vision Benefits
- ✓ Consolidated Benefits (CoBen) Cash Option
- ✓ FlexElect Cash Option
- ✓ FlexElect Medical & Dependent Care Reimbursement Accounts
- ✓ Annual Leave and Sick Leave/Vacation Programs
- ✓ Long Term Disability (Excluded Employees Only)
- ✓ Group Legal Services Insurance Plan

Refer to the "***Open Enrollment***" *section* of the Attendance Clerk Manual for detailed information.

# Civil Service Employee Benefits *Continue*

## Sample of Direct Deposit Form - STD 699 (Front)

STATE OF CALIFORNIA – CONTROLLER'S OFFICE

Print Form | Reset Form

**DIRECT DEPOSIT**

**ENROLLMENT AUTHORIZATION**

STD. 699 (REV. 12/2011)

This authorization remains in full force and effect until the State Controller's Office receives written notification from the employee of its termination, or until the State Controller's Office or appointing authority deems it necessary to terminate the agreement.

***COMPLETION INSTRUCTIONS AND PRIVACY NOTICE ARE ON THE REVERSE OF THE EMPLOYEE COPY. PLEASE TYPE OR USE BALL POINT PEN–PRINT CLEARLY.***

**SECTION A** *(To be completed by employee)*

1. TYPE OF ENROLLMENT ACTION
   1. ☐ NEW — SECTIONS A, B, AND C MUST BE COMPLETED
   2. ☐ CHANGE — SECTIONS A, B, AND C MUST BE COMPLETED
   3. ☐ CANCEL — SECTIONS A AND D MUST BE COMPLETED
2. SOCIAL SECURITY NUMBER
3. NAME (First Middle Last)

**SECTION B** *(To be completed by employee if **NEW** or **CHANGE** box in Section A is checked)*

1. TYPE OF ACCOUNT- MUST BE CHECKED, IF LEFT BLANK, WILL BE PROCESSED AS CHECKING
   ☐ C (Checking) ☐ S (Savings)

**Verify Routing/Depositor Numbers with Financial Institution**

2. ROUTING NUMBER
3. DEPOSITOR ACCOUNT NUMBER
4. FINANCIAL INSTITUTION NAME
5. FINANCIAL INSTITUTION ADDRESS (Number and Street City/ State ZIP)

**SAMPLE**

**SECTION C** *(To be completed by employee if **NEW** or **CHANGE** box in Section A is checked)*

I hereby authorize the State Controller's Office to provide for direct deposit of any salary or wages due me, less any mandatory or authorized withholding or deductions therefrom, in the above designated account.

If at any time the amount of salary or wages so deposited exceeds the amount of salary or wages actually due and payable to me, I hereby authorize the State Controller's Office to either:

(a) Withhold a sum equal to the overpayment from future salary or wages; or

(b) Recover such overpayment from the above-designated account.

If the State is legally obligated to withhold any part of my wage or salary payment for any reason, or if I no longer meet eligibility requirements for the Direct Deposit program, I understand the State Controller's Office may terminate my enrollment in the program. If any action taken by me results in nonacceptance of a direct deposit by the designated financial institution, I understand that the State assumes no responsibility for processing a supplemental salary or wage payment until the amount of the nonacceptance deposit is returned to the State by the financial institution.

☐ 100% of the net deposit will not be sent to a financial institution outside the jurisdiction of the United States.

SIGNATURE DATE

**SECTION D** *(To be completed by employee if **CANCEL** box in Section A is checked)*

I hereby cancel my Direct Deposit authorization.

SIGNATURE DATE

**SECTION E** *(To be completed by state agency or campus personnel/payroll office only)*

1. AGENCY/CAMPUS NAME
2. AGENCY CODE
3. UNIT

**FOR SCO ONLY**
1. EFFECTIVE DATE MO. DAY YR.

4. REMARKS
☐ CHECK BOX IF SEMI-MONTHLY EMPLOYEE

5. AUTHORIZED AGENCY/CAMPUS SIGNATURE

I HEREBY CERTIFY THAT I AM THE DULY APPOINTED, QUALIFIED AND ACTING OFFICER OF THE HEREIN NAMED AGENCY/CAMPUS AND THAT, BEING SO AUTHORIZED, DO CERTIFY THAT THIS EMPLOYEE IS ELIGIBLE FOR DIRECT DEPOSIT.

TELEPHONE NUMBER
☐ CHECK IF CALNET

DATE RECEIVED IN EMPLOYING OFFICE MO. DAY YR.

DISTRIBUTION: WHITE–TO STATE CONTROLLER'S OFFICE
CANARY–TO AGENCY
PINK–TO EMPLOYEE

***Note: The box in section C* must be check and *completed; incomplete documents will be sent back for completion and will delay the process.***

# Civil Service Employee Benefits *Continue*

## Sample of Direct Deposit Form - STD 699 (Back)

STATE OF CALIFORNIA – CONTROLLER'S OFFICE
STD. 699 (REV. 12/2011)
(Reverse of Employee copy)

### *PLEASE READ THIS INFORMATION CAREFULLY*

**COMPLETION INSTRUCTIONS**

1. To enroll in Direct Deposit, complete this form as follows:

**General Instructions**

- Complete Sections A, B and C if you are enrolling for the first time, re-enrolling after cancellation, or changing your existing Direct Deposit information.
- Complete Section A and D only if you are cancelling your enrollment.

**Specific Instructions**

- Section A — (Item 1) Type of Enrollment Action
  New–Complete for new enrollment or re-enrollment after cancellation
  Change–Complete to change type of account, financial institution branch (routing number), or depositor account number
  Cancel–Complete to cancel your Direct Deposit
- Section B — (Item 1) Indicate checking or savings. Only one box must be checked. If left blank, will be processed as **checking**.
  (Item 2) Enter Routing Number (cannot begin with a "5" and cannot exceed 9 digits)
  (Item 3) Enter Depositor Number (cannot exceed 17 digits)
- Section C — According to National Clearing House Association Operating Rules, effective September 18, 2009, you are not allowed to forward 100% of your net payment to a financial institution outside of the United States (U.S.). If 100% of the net deposit is being sent outside the jurisdiction of the U.S., you are no longer allowed to participate in the Direct Deposit program and must cancel your enrollment. A paper warrant will be issued to you effective the month the cancellation is processed.

  For new/change enrollments, please mark the box indicating you are aware of this requirement and are not sending 100% of the net deposit outside the jurisdiction of the U.S.

**IMPORTANT:** PLEASE VERIFY YOUR DEPOSITOR ACCOUNT NUMBER AND ROUTING NUMBER WITH YOUR FINANCIAL INSTITUTION.

2. Forward your completed form to your personnel/payroll office for completion of Section E.
3. Your first payment will be deposited into your designated account within 40 days after your form is received by the Controller's Office.

**DIRECT DEPOSIT POSTING DATES**

Funds for regular monthly or semi-monthly employees paid on the last day of the pay period should be available the first banking day after the end of the pay period. For example, if the pay period ends on a Wednesday, funds should be available on Thursday. If the pay period ends on a Friday, a weekend, or a holiday, funds should be available on the next banking day.

Funds for positive pay employees paid with a lag between the end of the pay period and pay day are available within two banking days after the issue date of the payment on the direct deposit earnings statement.

While most financial institutions post funds to accounts at the beginning of the bank business day, this is not a universal practice. Some institutions post funds in the afternoon instead of the morning. It is strongly recommended that you check with your financial institution to determine when your funds will be available.

**CHANGING FINANCIAL INSTITUTION OR DEPOSITOR ACCOUNTS**

Your Direct Deposit will continue to be deposited into your designated account at your financial institution until the State Controller's Office is notified that you wish to redesignate your account and/or your financial institution. To redesignate, complete and submit a new STD. 699 with the new information. ***DO NOT CLOSE YOUR OLD ACCOUNT UNTIL YOUR FIRST PAYMENT IS DEPOSITED INTO YOUR NEWLY DESIGNATED ACCOUNT AND/OR FINANCIAL INSTITUTION.*** Your first payment into your new account will be within 40 days after your form is received by the Controller's Office. You may receive a paper warrant during this period.

**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 for the purposes of identification and enrollment processing. It is mandatory to furnish all information requested on this form except for financial institution name, address and branch number or name. Failure to provide the mandatory information may result in the enrollment action not being processed or being processed incorrectly.

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 Enrollment Authorization are maintained in confidential files of the State Controller's Office for six years. Employees have the right of access to copies of their Enrollment Authorization forms upon request. The official responsible for maintenance of the forms is: Chief of Personnel/Payroll Operations Branch, State Controller's Office, P.O. Box 942850, Sacramento, California 94250-5878.

SAMPLE

# Civil Service Employee Benefits *Continue*

## Sample of Pre-Tax Parking - Cal-HR 682 (Front)

STATE OF CALIFORNIA
**PRE-TAX PARKING/THIRD-PARTY ADMINISTRATOR/REIMBURSABLE ACCOUNT ENROLLMENT**
CalHR-682 (03/04/2012)

**Instructions:** Read this form entirely before completing it. Questions regarding completion of this form should be directed to your personnel/payroll office. See privacy notice below. Please type or print clearly. To establish a new Third Party Pre-Tax Parking Reimbursement Account, complete this form, mark 1.A., and enter the amount in item #5 you want deducted each month from your paycheck and deposited in your reimbursement account. To change an existing enrollment, mark 1.B., and make the appropriate changes. To cancel your enrollment, mark 1.C. **Process this completed form with your department's payroll/personnel office.**

| 1. ENROLLMENT ACTION (check appropriate box) | 2. SOCIAL SECURITY NUMBER |
|---|---|
| A. ☐ New Enrollment ☐ Cancel Enrollment | |
| B. ☐ Change to Enrollment | 3. NAME (First, Middle, Last) |

SAMPLE

| BENEFIT ITEM | 4. For SCO Use Only DED/ORG CODE | 5. MONTHLY AMOUNT TO BE DEPOSITED TO ACCOUNT |
|---|---|---|
| Third-Party Pre-Tax Parking Reimbursement Account | 361-001 | $ [Not to Exceed Current Maximum Limits, Internal Revenue Service Code (IRSC) Section 132] |

6. ***Note: This form is not for use by employees using General Services parking, any department-sponsored parking, or other parking beginning with deduction codes 050 or 360.***

**Read carefully and sign below:** I hereby agree to voluntarily participate in a third-party administrator deduction program for reimbursable parking under IRSC Section 132 and to comply with IRSC laws and regulations. By taking this action, my monthly pay will be reduced by the amount specified above, so the State of California may set aside reimbursable amounts, as I have specified. I understand that requests for reimbursement must be for eligible expenses incurred after the effective date of my participation in the pre-tax parking program; that my deduction will continue until I take action to change or terminate this deduction; that I may be reimbursed only for qualified parking expenses, as defined under IRSC Section 132; that any unclaimed amount remaining in my pre-tax parking account can only be paid to me for qualified parking expenses under IRSC Section 132, while I am employed by the State of California; and that any unclaimed amount in my pre-tax parking account is subject to forfeiture. I have reviewed the information describing the State of California's third-party administrator parking reimbursement program, authorized under IRSC Section 132, and agree to the terms and conditions of the program.

| EMPLOYEE SIGNATURE | DATE SIGNED | PHONE NUMBER (WORK) |
|---|---|---|
| ▶ | | |

**AGENCY USE ONLY**

| 7. EFFECTIVE DATE OF ACTION MO DAY YEAR | 8. EMPLOYEE CBID | 9. AGENCY CODE | 10. UNIT CODE |
|---|---|---|---|
| 11. REMARKS | | 12. AGENCY NAME | |
| | | 13. 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 Parking Reimbursement Account. | |
| | | ▶ | 15. DATE RECEIVED IN EMPLOYING OFFICE (mo day year) |
| | | 14. TELEPHONE NUMBER (Indicate Area Code) | |

**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. The State Controller's Office and the plan administrator use information on this form for the purposes of identification and document processing. It is mandatory to furnish all information requested on this form. Failure to provide mandatory information may result in the claim not being processed, nonpayment of the claim, or the claim being processed incorrectly. The State Controller's Office requires an 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 (IRSC); and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

# Civil Service Employee Benefits *Continue*

**Sample of Pre-Tax Parking - Cal-HR 682 (Back)**

STATE OF CALIFORNIA
PRE-TAX PARKING/THIRD-PARTY ADMINISTRATOR/REIMBURSABLE ACCOUNT ENROLLMENT
CalHR-682 (4/5/2012)

P

**Important Information for Third Party Pre-Tax Parking Reimbursement Program (Program) Participants**

SAMPLE

**Forfeiture of funds**

The Program is regulated by Section 132 of the Internal Revenue Code (IRC) - Qualified Transportation Fringe Benefits. **The IRC does not allow for automatic refunds of excess money in your Pre-Tax Parking Reimbursement Account.**

Active State employees have one (1) year from the date of last activity (deduction or submission of a claim) to submit a claim with valid parking receipts for reimbursement.

Employees who have separated from State service also have one (1) year from their date of separation to submit a claim for reimbursement of work-related parking expenses incurred prior to separation.

**If you don't submit pre-tax parking reimbursement account claims within these specified time periods, you will forfeit the remaining balance in your account. Funds subject to forfeiture revert back to the State of California.**

If you have any questions regarding the forfeiture of funds, please contact the Program Coordinator at (916) 324-0526.

# Civil Service Employee Benefits *Continue*

**Sample of Annual Leave Form - CalHR 875**

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

**Annual Leave-Sick/Vacation Leave Election Form**
California Department of Human Resources
State of California

Print Form | Reset Form

SAMPLE

**1. EMPLOYEE INFORMATION**

Name | Social Security Number (last four digits)

Department/Location | Unit Number | Work Phone Number

**2. EMPLOYEES NOT COVERED BY SEIU BARGAINING UNITS**

I elect to participate in the following leave program effective the first day of the pay period this election is received by my personnel office.

- ☐ Annual Leave
- ☐ Sick Leave/Vacation

I understand I may change from Annual Leave to Sick Leave/Vacation or visa versa no more than once every 24 months.

**3. EMPLOYEES IN SEIU BARGAINING UNITS**

- ☐ Annual Leave
- ☐ Sick Leave/Vacation

I understand I may change from Annual Leave to Sick Leave/Vacation or visa versa annually during an open enrollment period during the month of April. The effective date of the election shall be the first day of the June pay period.

**4. APPROVAL**

I understand the accrual rate and usage provisions differ in the Annual Leave and Sick Leave/Vacation Programs. Further, if I am a current employee, I understand when I change from one program to another, all provisions of the program I enter apply upon the effective date. However, the annual leave, sick leave, or vacation balances I have on the effective date of the new program will continue to be available to me to use. If I have a sick leave balance upon retirement, I may convert it to PERS service credit according to Government Code section 20963.

I make this election freely and voluntarily.

Signature | Date

Note: New Employees: If this election form is not returned to the Personnel Office, it will be deemed an election for the sick leave/vacation program.

**4. FOR PERSONNEL OFFICE USE ONLY**

After processing election, place in employee's personnel file.

Date Election Received: | Received By:

Effective Date: | Date Eligible to Change:

CalHR 875 | Page 1 of 2 | (rev 04/2016)

# Civil Service Employee Benefits *Continue*

## Sample of Long Term Disability Form

Reset

Standard Insurance Company

**State of California, Group No. 643146**
**Long Term Disability**
**Enrollment and Change Form**

**LTD**

***Eligible Employee Instructions: Please mark all boxes and complete sections A, B, and C, either online or use a ball-point pen and print clearly. Send completed form to your Agency Personnel/Payroll Office. Please keep a copy for your records.***

**Section A Applicant**

1. Type of Enrollment ☐ New – Enrolling for the first time ☐ Canceling Plan ☐ Changing Plan Option
2. Your Soc. Sec. No.
3. Your Name (First, Middle, Last)
4. Date of Birth
5. Your Address
6. City
7. State
8. ZIP
9. Job Title/Occupation
10. Gender ☐ Male ☐ Female

SAMPLE

**Section B LTD Plan Options**

1. ***Please select your LTD Plan option below. Then complete item 2. Rates are effective April 1, 2014.***

☐ **OPTION A – 65% MISCELLANEOUS/NON-SAFETY/OASDI EMPLOYEES (075-111)**

| Under Age 30 | 30-39 | 40-49 | 50-59 | Over 60 |
|---|---|---|---|---|
| .00033 | .00096 | .00226 | .00453 | .00502 |

☐ **OPTION B – 65% PEACE OFFICERS/FIREFIGHTERS/SAFETY/NON-OASDI EMPLOYEES (075-112)**

| Under Age 30 | 30-39 | 40-49 | 50-59 | Over 60 |
|---|---|---|---|---|
| .00040 | .00112 | .00271 | .00599 | .00677 |

☐ **OPTION C – 55% MISCELLANEOUS/NON-SAFETY/OASDI EMPLOYEES (075-119)**

| Under Age 30 | 30-39 | 40-49 | 50-59 | Over 60 |
|---|---|---|---|---|
| .00016 | .00048 | .00113 | .00229 | .00254 |

☐ **OPTION D – 55% PEACE OFFICERS/FIREFIGHTERS/SAFETY/NON-OASDI EMPLOYEES (075-120)**

| Under Age 30 | 30-39 | 40-49 | 50-59 | Over 60 |
|---|---|---|---|---|
| .00022 | .00064 | .00152 | .00329 | .00369 |

2. ***Please calculate your monthly LTD premium by using the formula below.***

Premium Computation

_____ × _____ + .80 = _____
Monthly Base Salary * | Factor For Your Age From Options Above | Monthly LTD Premium

*** Not to exceed a monthly base salary of $18,182 for the 55% plan options and $15,385 for the 65% plan options.**

**Section C Signature**

I wish to make the choices indicated on this form. If electing to change coverage, I authorize deductions from my wages to cover my contribution, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. If I elect to cancel coverage in the LTD Plan, I understand I will not be able to re-enroll again until the next open enrollment period.

Employee Signature Required

Date (Mo/Day/Yr)

***Agency Personnel/Payroll Office: VERIFY EMPLOYEE'S PREMIUM COMPUTATION***

**Section D Agency Use Only**

1. Deduction Code 075
2. Organization Code
3. Deduction Amount
4. Agency Name
5. Effective Date
6. CBID
7. Agency Code
8. Rept. Unit
9. **AUTHORIZED AGENCY SIGNATURE**
I certify that authorization for payroll deductions signed by this employee and appointing the above-named company or organization as his/her agent is on file in this office.

SIGNATURE _____

10. Remarks/Eligibility date for "newly eligible employees" (beginning and ending date)
11. Telephone number
12. Date received in employing office

**Agency Distribution List:** Original and 1 copy TO SCO
1 copy TO EMPLOYEE
1 copy TO EMPLOYEE'S PERSONNEL FILE

Print

SI 7633D-643146 (4/14) (08/03)

# Civil Service Employee Benefits *Continue*

## Sample of Group Legal Services Insurance Plan (First page)

### State of California Group Legal Services Insurance Plan
### Online Enrollment Form Directions and Guidelines

**Completion of Enrollment/Cancellation Form**

Enrollment in the State of California Group Legal Services Insurance Plan is easy. Simply mark all boxes and complete Sections A and B online or use a ballpoint pen and print clearly.

SAMPLE

***Please Note:*** The Personnel Office must process the form to the SCO, the Personnel/Payroll Services Division, by the 10th of the month to enroll/cancel for the next pay period.

**To enroll using online enrollment form:**

1. Enter required information online in Sections A (1.a and 2-7) and B (1.a, b, c).
2. Make three copies of completed Enrollment Form and sign two copies (Section B.3).
3. Return all copies to your department's Personnel Office. Do not forward your enrollment form directly to either CalHR or ARAG®.
4. After the Personnel Office has processed the form, a copy will be returned to you, another copy will be placed in your file and two copies will be forwarded to the State Controller's Office (SCO) to establish the monthly payroll deduction.

**To change type of coverage using online enrollment form:**

1. Enter required information online in Sections A (1.b and 2-7) and B (1.a, b, c).
2. Make three copies of completed Enrollment Form and sign two copies (Section B.3).
3. Return all copies to your department's Personnel Office. Do not forward your enrollment form directly to either CalHR or ARAG.
4. After the Personnel Office has processed the form, a copy will be returned to you, another copy will be placed in your file and two copies will be forwarded to the State Controller's Office (SCO) to establish the monthly payroll deduction.

**To cancel your membership using online enrollment form:**

1. Enter required information online in Section A (1.c and 2-7) and Section B (2.a and b).
2. Make three copies of completed Enrollment Form and sign two copies (Section B.3).
3. Return all copies to your department's Personnel Office. Do not forward your enrollment form directly to either CalHR or ARAG.
4. After the Personnel Office has processed the form, a copy will be returned to you, another copy will be placed in your file and two copies will be forwarded to the State Controller's Office (SCO) to establish cancellation of the monthly payroll deduction.

You can also submit a written request directly to the SCO, Attention: Personnel/Payroll Services Division, P.O. Box 942850, Sacramento, CA 94250-5878. The request must include your name, Social Security number, organization code (081), deduction code (075) and be signed with an original signature authorizing cancellation of the deduction.

866-762-0972 | ARAGLegalCenter.com

150109v5 1

# Civil Service Employee Benefits *Continue*

## Sample of Group Legal Services Insurance Plan (Second page)

**SUBMIT COMPLETED FORM TO YOUR DEPARTMENT PERSONNEL/PAYROLL OFFICE**
**Do not send to CalHR**

**State of California**
**GROUP LEGAL SERVICES INSURANCE PLAN**
Underwritten by ARAG® Insurance Company, Des Moines, IA.

**No money needed to enroll — Payroll deduction.**

**SECTION A. Please type or complete in ballpoint pen. See privacy notice on back side.**

**1. Type of Action** (Check one)
- a. ☐ NEW ENROLLMENT – Complete sections A (1–7) and B (1&3)
- b. ☐ CHANGE OF COVERAGE – Complete sections A (1–7) and B (1&3)
- c. ☐ CANCEL COVERAGE– Complete sections A (1–7) and B (2–3)

**2. Social Security Number**

**3. Date of Birth** Month Day Year

**4. Primary Mailing Address**

**5. Name in Full** First Middle Initial Last

**6. Mailing Address** Number and Street

City State ZIP Code

**7. Daytime Telephone Number** ( ) – – ext.

SAMPLE

**SECTION B. Please check appropriate box, read and sign.**

1. ☐ I authorize deductions to be made from my salary to cover my share of enrollment in the State's Group Legal Services Insurance Plan as it is now or as it may be in the future with coverage as shown below.

Please check type of coverage to be elected and monthly premium amount (check one only).
- a. ☐ **Individual $10.04/month**
- b. ☐ **Family/Registered Domestic Partner $17.59/month***

*Declaration of Domestic Partnership (Family Code Section 298) registered with the Secretary of State.

If you selected Family or Domestic Partner coverage, please list spouse/domestic partner and unmarried dependent children below.

| Name | Date of Birth | Name | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |

2. a. ☐ I elect to cancel the Group Legal Services Insurance Plan

b. Reason for cancellation (optional)

**3. Please read and sign.**

Enrollment is hereby made for coverage as indicated above, for all persons listed herein, subject to all terms and conditions of the contract for which the enrollment is made. I understand that my effective date of coverage will begin on the first day of the pay period following my first payroll deduction. I certify that all information entered is true. I fully understand the waiting periods and limitations of the plan coverage.

In connection with my enrollment for benefits through ARAG Insurance Co., I hereby authorize the above monthly premium deduction be made from my salary which also includes a monthly administrative fee payable to the State through payroll deduction. I further understand the premiums shown above include an administrative cost incurred by the State, which may be increased without prior notice.

**Signature** X _____ **Date** X Month / Day / Year

**SECTION C. To be completed by agency personnel office. Note this section is audited by SCO.**

| 1. Deduction code | 2. Organization code | 3. Deduction amount (Circle one) | 4. Agency name | 5. Date received in employing office |
|---|---|---|---|---|
| 075 | 081 | $10.04 or $17.59 | | Month / Day / Year |
| 6. CBID | 7. Agency code | 8. Rept. unit code | 12. AUTHORIZED AGENCY SIGNATURE I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State's Group Legal Services Insurance Program. | |
| 9. Remarks—for newly eligible employee status changes | | 10. Permitting event date Month / Day / Year | Telephone ( ) – (indicate if CALNET or government code) | |
| 11. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only). | | | 13. Effective date of coverage Month / Day / Year | |

Original and One Copy to SCO — One Copy to Employee's Personnel File — One Copy for Employee

08/10 rev. SCO_0114

Group Number: 102 02

# Civil Service Employee Benefits *Continue*

## Sample of Group Legal Services Insurance Plan (Third page)

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.

SAMPLE

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, except for marital status, which may be furnished on a voluntary basis and is used by the plan administrator for statistical purposes. Failure to provide the mandatory information may result in Group Legal Services Insurance Plan 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.

Information provided on the form will be forwarded to the plan administrator. Copies of the Group Legal Services Insurance Plan Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Enrollment Authorization forms upon request.

Insurance products are underwritten by ARAG® Insurance Company of Des Moines, Iowa. Service products are provided by ARAG Services LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call our toll-free number.

If you have specific questions regarding the Plan or if you need assistance in completing the enrollment form, please contact an ARAG Customer Care Specialist toll-free at 866-762-0972 (or for TTY 800-383-4184), or 711 to reach a relay operator.

# Civil Service Employee Benefits *Continue*

## Sample of Request Non-Disclosure of Home Address Form - STD 677

STATE OF CALIFORNIA

**REQUEST FOR NONDISCLOSURE OF EMPLOYEE HOME ADDRESS**

STD. 677 (NEW. 2-99)
*(Corrected 3-99)*

Clear Print

SAMPLE

PLEASE TYPE OR USE BALLPOINT PEN - PRINT CLEARLY

| NAME *(Last, First, Middle Initial)* | SOCIAL SECURITY NUMBER |
|---|---|
| | |

Pursuant to Government Code Section 6254.3:

(a) The home addresses and home telephone numbers of state employees and employees of a school district or county office of education shall not be deemed to be public records and shall not be open to public inspection, except that disclosure of that information may be made as follows:

(1) To an agent, or a family member of the individual to whom the information pertains.

(2) To an officer or employee of another state agency, school district, or county office of education when necessary for the performance of its official duties.

(3) To an employee organization pursuant to regulations and decisions of the Public Employment Board, except that the home addresses and home telephone numbers of employees performing law enforcement-related function shall not be disclosed.

(4) To an agent or employee of a health benefit plan providing health services or administering claims for health services to state, school districts, and county office of education employees and their enrolled dependents, for the purpose of providing the health services or administering claims for employees and their enrolled dependents.

(b) Upon written request of any employee, a state agency, school district, or county office of education shall not disclose the employee's home address or home telephone number pursuant to paragraph (3) of subdivision (a) and an agency shall remove the employee's home address and home telephone number from any mailing list maintained by the agency, except if the list is used exclusively by the agency to contact the employee.

**CHECK APPROPRIATE BOX**

☐ I request that my home address not be disclosed as provided by Government Code Section 6254.3(b). I understand that my home address can be disclosed to specified individuals or organizations under Government Code Sections 6254.3.

☐ I cancel my previous request of having my home address not be disclosed.

**PRIVACY NOTICE**

The Information Practices Act of 1977 (California Civil Code Section 1798.17) and the Federal Privacy Act (5 USC 552a, subd. (e)(3)) require this notice to be provided when collecting personal information from individuals. Information requested on this form, which includes the social security number, is used for the purposes of identification and the address withhold processing. Furnishing the requested information on this form is mandatory. Failure to provide the mandatory information may result in the address withhold action not being processed or being processed incorrectly.

Legal references authorizing the maintenance of this information include: Federal Internal Revenue Code (26 USC Sections 3402(a), 6011, 6051, and 6109) and the regulations thereto; and California Government Code Sections 12470 through 12479 and 16391 through 16395; delegated authority from the State Personnel Board; and delegated authority from the Trustees of the California State University.

Employees have the right to review their own personal information maintained by the State Controller's Office unless access is denied by law. Contact: Personnel/Payroll Services Division, State Controller's Office, P.O. Box 942850, Sacramento, CA 94250-5878.

| EMPLOYEE SIGNATURE | DATE SIGNED |
|---|---|
| | |

**PERSONNEL OFFICE USE ONLY**

| REVIEWER'S SIGNATURE | | TELEPHONE NUMBER ( ) | DATE REVIEWED |
|---|---|---|---|
| AGENCY | UNIT | KEYED BY | DATE KEYED |

# Civil Service Employee Benefits *Continue*

## Sample of Designation of Person(s) Authorizes to Receive Warrants - STD 243

Print Clear

STATE OF CALIFORNIA – STATE CONTROLLER'S OFFICE

**DESIGNATION OF PERSON(S) AUTHORIZED TO RECEIVE WARRANTS (GC § 12479)**

STD. 243 (REV. 08/2011)

EMPLOYEE NAME (First, Middle, Last)

NAME OF EMPLOYING STATE AGENCY | AGENCY/CAMPUS (Unit)

SAMPLE

Pursuant to Section 12479 of the Government Code, I hereby designate the following person(s) or estate or corporation which, notwithstanding any other provision of the law, shall be entitled **upon my death** to receive all state warrants that would have been payable to me had I survived.
*NOTE: Direct deposit payments are not subject to the provisions of this designation.*

**Important:** This is NOT a designation for payment of death benefits or refund of employee retirement contributions. A form PERS-BSD-241, Beneficiary Designation, must be completed to file a designation with the California Public Employees' Retirement System for death benefits.

**PRIMARY DESIGNEE** ***(Must be 18 years of age or older)***

| PRIMARY DESIGNEE NAME *(First, Middle, Last)* | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
|---|---|---|
| ADDRESS | CITY AND STATE | ZIP CODE |

**CONTINGENT DESIGNEE(S)** ***(Must be 18 years of age or older)***

| FIRST CONTINGENT DESIGNEE NAME *(First, Middle, Last)* | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
|---|---|---|
| ADDRESS | CITY AND STATE | ZIP CODE |
| SECOND CONTINGENT DESIGNEE NAME *(First, Middle, Last)* | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
| ADDRESS | CITY AND STATE | ZIP CODE |
| THIRD CONTINGENT DESIGNEE NAME *(First, Middle, Last)* | RELATIONSHIP TO EMPLOYEE | TELEPHONE NUMBER |
| ADDRESS | CITY AND STATE | ZIP CODE |

I hereby revoke all designations that I have previously filed.

The primary designated person shall be the designated person that receives the warrants. If the primary designated person predeceases the employee, the next designated person who survives the employee will receive the warrant(s).

If the above-named designee does not file a written request with the personnel/payroll office of my employing state agency/campus for such warrants within sixty (60) days after the date of my death, this designation shall be and become null and void.

This designation will remain in full force and effect during my employment with any California state agency/campus until revoked in writing by me.

| EMPLOYEE HOME ADDRESS | | FOR AGENCY/CAMPUS USE ONLY<br>REVIEWED BY THE PERSONNEL/PAYROLL OFFICE AND FILED<br>SIGNATURE OF AUTHORIZED OFFICER ▶ | |
|---|---|---|---|
| CITY, STATE, ZIP CODE | | TYPED NAME | DATE |
| EMPLOYEE SIGNATURE *(Please sign in ink)* ▶ | DATE SIGNED | | |

***INSTRUCTIONS***

1. Complete this form; print clearly in ink or type all information requested.
2. Show the full name of all designees; for example, "Mary Jane Smith", not Mrs. John E. Smith.
3. Specify the relationship of each person designated, such as wife, husband, domestic partner, daughter, son, mother, father, parent, friend, etc.
4. Verify that the form is complete and correct. No erasures or corrections may be made in the name of the primary designee or contingent(s). If any error has been made, complete a new form.
5. Sign the form in ink and submit to your personnel/payroll office. A copy will be returned to you for your records.
6. You may change your designation at any time by filing a new form STD. 243 with your personnel/payroll office.
7. You may completely revoke a designation at any time by submitting either of the following with original signature: A new form STD. 243 indicating "NONE" for the primary designee name or a letter to your employer.
8. Inform your personnel/payroll office when a change occurs in your primary designee's or contingent's address.
9. You may wish to file a new designation upon any change in your marital or domestic partnership status.

# Civil Service Employee Benefits *Continue*

## Sample of Authorization to Use a Privately Owned Vehicle on State Business

**STD 261**

STATE OF CALIFORNIA

**AUTHORIZATION TO USE PRIVATELY OWNED VEHICLES ON STATE BUSINESS**

STD. 261 (REV. 3-95)

***This approval must be renewed annually.***
*Supervisor: Retain Original Copy*

**I. CERTIFICATION**

In accordance with State Policy *(S.A.M. 0753 & 0754)* approval is requested to use privately owned vehicles to conduct official State business.

*I hereby certify that*, whenever I drive a privately owned vehicle on State business, I will have a valid driver's license and proof of liability insurance in my possession, all persons in the vehicle will wear safety belts, the vehicle will always be:

1. Covered by liability insurance for the minimum amount prescribed by State Law ($15,000 for personal injury to, or death of one person; $30,000 for injury to, or death of, two or more persons in one accident; $5,000 property damage.) Vehicle Code Section 16020 (effective July 1, 1985) requires all motorists to carry evidence of current automobile liability insurance in their vehicle.
2. Adequate for the work to be performed.
3. Equipped with safety belts in operating condition.
4. To the best of my knowledge, in safe mechanical condition as required by law.

I understand that the mileage rate I claim is full reimbursement for the cost of operating the vehicle, including fuel, maintenance, repairs and both liability and comprehensive insurance.

*I further certify that* while using a privately owned vehicle on official State business, all accidents will be reported on form STD. 270 within 48 hours *(S.A.M. 2441)*.

I understand that permission to drive a privately owned vehicle on State business is a privilege which may be suspended or revoked at any time.

| DRIVER'S LICENSE NUMBER | STATE | EXPIRATION DATE |
|---|---|---|
| EMPLOYEE'S SIGNATURE | PRINT NAME | DATE SIGNED |

**II. APPROVAL**

*Use of a privately owned vehicle on State business is approved.*

| APPROVING AUTHORITY SIGNATURE | TITLE | DATE APPROVED |
|---|---|---|

**III. RENEWAL**

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

*I have reviewed the above certification and approval and certify that the information provided is correct and valid.*

| EMPLOYEE'S SIGNATURE | APPROVING AUTHORITY SIGNATURE | DATE APPROVED |
|---|---|---|

SAMPLE

# Civil Service Employee Benefits *Continue*

**Sample of Request for Voluntary Personal Leave Program (VPLP)**

## REQUEST FOR VOLUNTARY PERSONAL LEAVE PROGRAM (VPLP) 06/14

| NAME: | DIVISION/UNIT: |
|---|---|

**PART 1: EXCLUDED EMPLOYEES**
**VPLP CONDITIONS 1-10 BELOW APPLY**

I request approval to participate in the VPLP for: ☐ 1 day (8 hours) ☐ 2 days (16 hours)
I understand my pay will be reduced equivalent to the number of day(s) I have selected and VPLP credits will be available to use on the first day of the monthly pay period following each month of participation in the VPLP.

**PART 2A: RANK-AND-FILE EMPLOYEES R01, R04, R09, R10, R11, R14, R15, R16, R17, and R20**
**ONLY VPLP CONDITIONS 7-10 BELOW APPLY**

I elect to participate in the VPLP for: ☐ 1 day (8 hours) ☐ 2 days (16 hours)

I understand my pay will be reduced equivalent to 1 day and VPLP credits will be available to use on the first day of the monthly pay period following each month of participation in the VPLP.

**PART 2B: RANK-AND-FILE EMPLOYEES R19 AND R21**
**ONLY VPLP CONDITIONS 5-10 BELOW APPLY**

I elect to participate in the VPLP for: ☐ 1 day (8 hours) ☐ 2 days (16 hours)
I understand my pay will be reduced equivalent to the number of day(s) I have selected and VPLP credits will be available to use on the first day of the monthly pay period following each month of participation in the VPLP.

**PART 3: VPLP CONDITIONS**

I understand that the following conditions apply to the VPLP:

1. Participation in the program is on a voluntary basis, subject to approval of my supervisor.
2. Only permanent, full-time employees can participate in the program.
3. The department reserves the right to cancel the program on a departmental, subdivisional, or individual basis at any time with thirty (30) days notice to participating employees.
4. Should I transfer to another department, my continued participation in the program will be at the discretion of the new department.
5. I must remain in the program for twelve (12) months or unless the department establishes a lesser time period.
6. Request to cancel participation will only be granted in cases of a financial hardship and must be approved by my supervisor.
7. Personal Leave must be requested and used in the same manner as vacation or annual leave.
8. There will be no impact on my benefits, leave credits, State service credit, or the final compensation used to calculate my State retirement benefits.
9. Should I be placed on Industrial Disability Leave, Non-Industrial Disability Leave, or Workers' Compensation for an entire monthly pay period, I will be excluded from the VPLP for that month.
10. Personal Leave shall not be included in the calculation towards the cap for vacation or annual leave balances.

**PART 4: ☐ I ELECT TO CANCEL MY PARTICIPATION IN THE VPLP**

I have read and understand the program conditions described in Part 3 above and accept the unpaid personal leave days as requested in Part 1 (Excluded Employees) or Part 2A and 2B (Rank-and-File Employees).

Employee Signature: _____ Date: _____

EXCLUDED EMPLOYEE APPROVALS;
Supervisor Signature _____ Date: _____
Division Chief Signature: _____ Date: _____

PERSONNEL TRANSACTIONS
Date Received in Personnel Transaction: _____ Personnel Specialist Signature:
Effective Date of VPLP:

SAMPLE

*LEFT BLANK*

# Health Benefits

CalPERS administer health plans for State employees. Employees can choose from a broad range of health plans. The Employee share and State share of premiums are based on the employee's Bargaining Unit.

This section contains the following topics:


| Topic | See Page |
|---|---|
| Eligibility | 220 |
| Permanent Intermittent Employees | 220 |
| Enrollment | 220 |
| Instruction of Completing Form HBD 12 | 225 |
| Affordable Care Act (ACA) | 231 |
| Dependent Eligibility Verification Checklist CalHR 781 | 231 |
| HIPAA | 231 |
| Life Events (Permitting Events) | 232 |
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| Mandatory Deletions | 234 |
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| Disenrollment of Ineligible Family Members | 234 |
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| Domestic Partnership | 236 |
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| Open Enrollment | 251 |
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| CalPERS Rescind Health Transactions | 251 |
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| Misc. Enrollment Information | 255 |
| Flex Cash Option (Opt Out of Health) | 255 |
| Health Benefit Coverage into Retirement | 255 |

# Health Benefits *Continue*

### Eligibility

Active employees who work at least half-time or more with an appointment of **six months and one day** are eligible for health benefits. Eligible employees have 60 calendar days from the date of appointment or a qualifying event to enroll, add or delete dependents, and make qualifying changes in a health plan, or wait for the Open Enrollment period.

**State Permanent-Intermittent** (PI) employees, is determined within one of two control periods:

- The 6-month period - January 1 through June 30 (effective enrollment date of August 1); or
- July 1 through December 31 (effective enrollment date of February 1)

An employee cannot attain eligibility in the middle of a control period, even if they met the minimum hours at the beginning of the period. To become eligible, they must:

- Receive credit for a minimum of 480 paid hours at the end of a control period

To continue their eligibility, they must:

- Be credited with at least 480 paid hours at the end of each control period; or
- Have at least 960 hours in two consecutive control periods (current and prior)
  June 30 and December 31 are the checkpoints to use to determine whether the hour requirements have been satisfied.

### State Limited-Term Employees

To be eligible to enroll, you must have served in excess of six months and you must have worked at least half-time. Check with your personnel office for further information.

### Enrollment

Employees have 60 calendar days from the date of an eligible appointment to enroll in a health plan. Coverage becomes effective the first day of the month following the date a completed Health Benefits Plan Enrollment Form HBD 12 and Declaration of Health Coverage HBD 12A is received in by the Health Benefits Officer or Personnel Specialist. Only one election is allowed during this 60 day period.

If an employee would like to change plans or add eligible family members, they must do so during the next Open Enrollment period. Open Enrollment changes take effect the following January 1.

***Note:*** *Incomplete documents will be sent back to the Attendance Clerk for completion and will cause a delay in process. Prior to submission to OHR, review ALL documents for completeness and accuracy. Submit documents timely to avoid an inconvenience to the employee*.

# Health Benefits *Continue*

## Health Benefit Forms Completion

The forms required for enrollment are the Declaration of Health Coverage Form HBD 12A, and the Health Benefit Plan Enrollment Form HBD 12. The complete Instructions for completing HBD 12 can be found on CalPERS website at:

https://www.calpers.ca.gov/docs/forms-publications/health-benefits-enroll-instructions.pdf

### Sample of Declaration of Health Coverage Form (HBD12A) Front

CalPERS

**Health Account Services**
P.O. Box 942715
Sacramento, CA 94229-2715
**(888) CalPERS** (or **888**-225-7377)
TTY (877) 249-7442
FAX (800) 959-6545

**Declaration of Health Coverage: HBD-12A** **(INSTRUCTIONS ON REVERSE)**

| EMPLOYEE INFORMATION<br>SOCIAL SECURITY NUMBER<br>_____-_____-_____ | NAME (FIRST) _____ (MIDDLE) _____ (LAST) _____ |
|---|---|
| **PART A**<br>☐ I elect to enroll myself and all eligible dependents. | |
| **PART B-1**<br>☐ I elect to enroll myself. My eligible dependents have other health insurance coverage. | If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment within 60 days from the date you lose coverage.<br><br>If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90-day waiting period or the Open Enrollment effective date. |
| **PART B-2**<br>☐ I elect to enroll myself and all eligible dependents. I also have eligible dependents who have other health insurance coverage. | |
| **PART C-1**<br>☐ I decline enrollment for myself and my eligible dependents because we have other health insurance coverage. | |
| **PART C-2**<br>☐ I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage. | You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date. |

**PART B: If you are currently enrolled** in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependents, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

**PART C: If you are not currently enrolled** in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependents, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

| Member's Signature | Date Signed | Health Benefits Officer's Signature |
|---|---|---|
| Rev 10/13 | Original: Employee's Personnel File | Copy: Employee |

SAMPLE

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Sample of Declaration of Health Coverage Form (HBD12A) Back**

## INSTRUCTIONS – DECLARATION OF HEALTH COVERAGE (HBD-12A)

| Please contact your Health Benefits Officer if you have any questions regarding the HBD-12A. | |
|---|---|
| **Employee Information** | Complete with the appropriate employee information. |
| **Part A:** | Mark this box if you are:<br>a) Enrolling in the Health Benefits Program and have no dependents, or<br>b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program. |
| **Part B-1:** | Mark this box if you are:<br>a) Enrolling yourself only, your dependents have other health insurance coverage, or<br>b) Canceling your dependents' coverage because they have other health insurance coverage |
| **Part B-2:** | Mark this box if you are:<br>a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or<br>b) Canceling coverage for some of your dependents because they have other health insurance coverage. |
| **Part C-1:** | Mark this box if you are:<br>a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or<br>b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage. |
| **Part C-2:** | Mark this box if you are:<br>a) Declining enrollment or canceling your health insurance for reasons other than having health insurance coverage and you have no dependents, or<br>b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage. |

SAMPLE

**IMPORTANT:** It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

**Special rules for retirement and death:**

Consider these points as you decide whether to enroll, decline, or cancel enrollment for yourself or dependents:

- If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.

# Health Benefits *Continue*

## Health Benefit Forms Completion Continue

### Sample of Health Benefit Plan Enrollment Form (HBD 12) Front

CalPERS

California Public Employees' Retirement System
P.O. Box 942715
Sacramento, CA 94229-2715

HEALTH BENEFIT PLAN
ENROLLMENT FORM
PERS-HBD-12 (Rev. 6/13)

**DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS**

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

SAMPLE

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☐ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER

3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

4A. Name

Mailing Address (FIRST) (MI) (LAST)

City, State, ZIP | Daytime Phone | Evening Phone

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. GENDER ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Reason Code

15. Permitting Event Date Mo. Day Yr.

16. EFFECTIVE DATE Mo. Day 01 Yr.

LIST ALL PERSONS (including self) TO BE ENROLLED IN:

| | | DATE OF BIRTH | Family Relationship | GENDER | CODE |
|---|---|---|---|---|---|
| 17. BASIC PLAN | | Mo. Day Yr. | | M F | |
| (FIRST) | (MI) (LAST) | | SELF | | |
| SSN | | | | | |
| (FIRST) | (MI) (LAST) | | | | |
| SSN | | | | | |
| (FIRST) | (MI) (LAST) | | | | |
| SSN | | | | | |
| (FIRST) | (MI) (LAST) | | | | |
| SSN | | | | | |
| | | | | | |
| 18. SUPPLEMENTAL PLAN | | DATE OF BIRTH | Relationship | | CODE |
| (FIRST) | (MI) (LAST) | Mo. Day Yr. | | | |
| | | | | | |
| | | | | | |

19. CHECK ONE
- ☐ I DO NOT elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy)

TELEPHONE NUMBER ( )

21. DATE SIGNED Mo. Day Year

**PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27**

22. DEDUCTION PLAN CODE

23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System)

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22870-22905 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office Mo. Day Year

34. PHONE NUMBER

35. REMARKS

_____ of _____ Forms

WHITE – HB PINK – Agency BLUE - Employee

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Sample of Health Benefit Plan Enrollment Form (HBD 12) Back**

## PRIVACY INFORMATION

Submission of the requested information is mandatory. The information requested is collected pursuant to the California Government Code (sections 20000 et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act as the case may be. Portions of this information may be transferred to another governmental agency (such as your employer) but only in strict accordance with current statutes regarding confidentiality. Failure to supply the information may result in the System being unable to perform its functions regarding your status.

SAMPLE

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and state benefits. Furthermore, Health Account Services requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits. Specifically, the California Public Employees' Retirement System uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the Public Employees' Retirement System and other state agencies.
5. Coordination of benefits among carriers.

---

## BINDING ARBITRATION

Enrollment in certain plans constitutes an agreement to have any issue of medical malpractice decided by neutral arbitration and waiver of any right to a jury or court trial. Refer to the health plan Evidence of Coverage booklet to determine if this provision is applicable to your plan.

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

## HBD-12

### Introduction

Members with active employment status must complete and submit an HBD-12 form to their employer before enrolling for health benefits. Employers keep the completed HBD-12 in a file and should give the member a copy.

### HBD-12 Instructions

The table below details the steps you must take to complete an HBD-12 form.

### Members and Employers

| Active Members | Employers |
|---|---|
| Please complete the following boxes 1, 2, 3, 4A, 4B, 5, 6, 7, 11, 17, 18, 19, 20 and 21.<br><br>Contact your employer's Health Benefits Officer (HBO) or Personnel Office if you require further assistance. | Please complete the following boxes 8, 9, 10, 12, 13, 14, 15, 16, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35.<br><br>If an employee requires assistance completing this form, please provide support where possible. |

| Retired Members | | |
|---|---|---|
| | To make an Open Enrollment change, complete the request form **HBD-30**, and mail it to CalPERS. If you prefer, you may call CalPERS to make changes over the phone. All changes are subject to verification of eligibility. | |
| | Mail HBD-30 requests to:<br><br>Health Account Services<br>P.O. Box 942715<br>Sacramento, CA<br>94229-2715 | Or Contact CalPERS with questions<br><br>**888 CalPERS** (or **888**-225-7377)<br>TTY (877) 249-7442<br>Fax (800) 959-6545 |

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

<table>
<tr><th>Box</th><th>Process</th></tr>
<tr><td><u>1</u><br>Type of Action<br><br>(required)</td><td>Check one:<br><table><tr><td>New</td><td>Not enrolled</td></tr><tr><td>Change</td><td>Is enrolled and either<br>• Changing health plans (when authorized)<br>• Adding family members<br>• Deleting family members<br>• Changing to a Medicare Coordinated plan (at retirement)</td></tr><tr><td>Cancel</td><td>Canceling all coverage</td></tr></table></td></tr>
<tr><td><u>2 and 3</u><br>Social Security Number<br><br>(required)</td><td>Enter your Social Security Number (SSN) and spouse or domestic partner's SSN. You may process this form without aSSN; however, you must provide each one as soon as possible.</td></tr>
<tr><td><u>4A</u><br>Name and Mailing Address</td><td>Enter your name as shown on the appointment document. Do not use nicknames. Enter your RESIDENCE or mailing address.</td></tr>
<tr><td><u>4B</u><br>Residence ZIP Code</td><td>Enter a residence ZIP Code to find an eligibility ZIP Code. If a mailing address is different from the residential address, include the Residence ZIP Code in Box 4B. If you decide to use a work ZIP Code, include that ZIP Code in Box 4A.</td></tr>
<tr><td><u>5</u><br>Permanent Intermittent<br><br>(State/CSU Only)</td><td>Check this box if you are Permanent Intermittent (PI) employee.</td></tr>
<tr><td><u>6 and 7</u><br>Gender and Marital Status</td><td>Check the appropriate box:<br><br>Yes - if married, separated<br>No - if unmarried or received a final divorce decree</td></tr>
<tr><td><u>8</u><br>Health Plan name</td><td>Refer to the Health Benefits Summary publication for a complete listing of all the CalPERS health plans on line at www.calpers.ca.gov, in the Forms and Publications Center. Enter the correct name of the health plan of your choice.</td></tr>
</table>

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

| Box | Process |
|---|---|
| 9<br>Health Plan Code | Refer to the annual Health Plan Rates located online at **www.calpers.ca.gov**, in the Forms and Publications Center. Enter the correct health plan code for the employee. |
| 10<br>Gross Premium | Using the applicable rate sheet, enter the full gross premium as shown in *dollars* and cents. For assistance, access **CalPERS On-Line**, at **www.calpers.ca.gov** and search for the annual *Health Plan Rates.* |
| 11<br>Primary Care Physician | Enter the name of a primary care physician and/or medical group. If you select an HMO but do not designate a Primary Care Physician/Medical Group, the plan will select one for you. |
| 12<br>Prior Health Plan | Enter prior health plan only if the employee is changing plans or canceling coverage. |
| 13<br>Prior Plan Code | Enter prior plan code only if the employee is changing plans or canceling coverage. For assistance, access **CalPERS On-Line**, at **www.calpers.ca.gov** and search for the annual *Health Plan Rates.* |
| 14<br>Permitting Event Code<br>*(Reason Code)* | Enter the appropriate transaction code, by locating the appropriate code in the Events/Reason Codes section of your manual. Complete a separate HBD-12 for each transaction that involves a different reason code or effective date. |
| 15<br>Permitting Event Date<br>*(required)* | Enter the date of an event that permits a change.<br><br>Examples: The employee's appointment date, the date of marriage or divorce, the date of death, or the birth date of a dependent. |
| 16<br>Effective Date<br><br>Permissive and Mandatory Transactions | **Permissive transactions** are effective on the first of the month following the date the agency receives an enrollment form (Box 33), within 60 days of event.<br><br>**Mandatory transactions** are effective on the first of the month following an event (Box 15). For Open Enrollment transactions, refer to the Open Enrollment section of your manual. For additional information on effective dates, refer to the Events, Effective Dates and Reason Codes sections of your manual. |

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

<table>
<tr><th>Box</th><th>Process</th></tr>
<tr><td><u>17 and/or 18</u><br>Enrolled Family Members</td><td>Use the appropriate Action Code to indicate additions or deletions of family members.
<table>
<tr><th>Action Code</th><th>Procedure</th></tr>
<tr><td>A</td><td>Use A to indicate the addition of family members (s), such as a new enrollment; mark the Action Code to the left of each enrollee's name.</td></tr>
<tr><td>D</td><td>Use D to indicate the deletion of family members (s)</td></tr>
</table>
Note: Do not use Action Codes to change plans or to cancel coverage (use boxes 1 and 19 to change plans or cancel coverage). When adding or deleting dependents, place an Action Code next to their name (s), then list additional family members' names (but do not add an Action Code).<br><br>
List all family members as follows (avoid nicknames):<br>
• First Name (full)<br>
• Middle (abbreviation)<br>
• Last name (full)<br><br>
List birthdate(s) as: MM/DD/YYYY<br><br>
If possible, list Social Security Numbers for dependents other than a spouse (required) in Box 35 (Remarks).<br><br>
Abbreviations for family relationship codes:
<table>
<tr><th>Family Relationship</th><th>Abbreviation</th></tr>
<tr><td>Wife</td><td>Wife</td></tr>
<tr><td>Husband</td><td>Husb</td></tr>
<tr><td>Daughter</td><td>Dtr</td></tr>
<tr><td>Son</td><td>Son</td></tr>
<tr><td>Stepson</td><td>S/Son</td></tr>
<tr><td>Stepdaughter</td><td>S/Dtr</td></tr>
<tr><td>Adopted Son</td><td>A/Son</td></tr>
<tr><td>Adopted Daughter</td><td>A/Dtr</td></tr>
<tr><td>All Others</td><td>Specify</td></tr>
</table>
List gender of family member.<br><br>
Note: A Family Code is not required.</td></tr>
</table>

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

| Box | Process |
|---|---|
| **19**<br>**Check One** | **I do not wish to enroll** — Check this box only when you wish to decline Health Benefits coverage. Request a copy from your HBO or Personnel Office.<br>**I elect to enroll** — Check this box for new enrollments and enrollment changes.<br>**I elect to cancel** — Check this box only for cancellation of all coverage, including "self." Do not check this box when deleting a family member. |
| **20**<br>**Employee** *or* **Annuitant Signature** | You **must sign the HBD-12.**<br><br>By doing so you:<br>• Authorize premium deductions<br>• Verify a health plan selection<br>• Verify the eligibility of all enrolled family members<br>• Please include a daytime phone number |
| **21**<br>**Date Signed** | Enter the month, day, and year.<br><br>Remember: *Permissive enrollment transactions are valid only when they are received in the employer's office and dated within 60 calendar days from the event date.*<br><br>**This is the last BOX a member/employee completes; the rest of the form must be processed by an HBO.** |
| **22-27**<br>(Active State Employees only… all others, skip to Box 28) | Note: The State Controller's Office requires this information to start, change, or stop premium payments.<br>Do not complete Boxes 22-27 if the transaction does not affect the premium payment, such as when adding a fourth family member. |
| **22**<br>**Deduction Code** | Refer to Box 8 for instructions. Enter the 3-digit plan code, excluding the party code (last digit).<br><br>Examples: Kaiser code 563 Coverage, enter: **056** (3 digit codes are preceded by 0). CCPOA Code **2742** Coverage, enter: **274.** |
| **23**<br>**Type of Action** | Check the appropriate box (same as Box 1)<br><br>Note: The cancel and change boxes are listed in reverse order for key-entry reasons. |

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

<table>
<tr><td><u>24</u><br>Pay Period</td><td>A pay period is the month prior to an effective date. In the three boxes, enter two digits for the pay period month and a last digit for the appropriate year.<br>Examples:<br><table><tr><th>Pay Period</th><th>Digits</th></tr><tr><td>11/01/13</td><td>10 13</td></tr><tr><td>03/05/13</td><td>0213</td></tr></table></td></tr>
<tr><td><u>25</u><br>Party Code</td><td>Enter the last digit of the plan code (1, 2, or 3).</td></tr>
<tr><td><u>26</u><br>Employee Designation</td><td>Enter the appropriate alpha code:<br><table><tr><th>Alpha Code</th><th>Designation</th></tr><tr><td>R</td><td>Rank and file employees</td></tr><tr><td>S</td><td>Supervisory employees</td></tr><tr><td>M</td><td>Management</td></tr><tr><td>C</td><td>Confidential employees</td></tr><tr><td>E</td><td>Excluded</td></tr></table></td></tr>
<tr><td><u>27</u><br>Bargaining Unit</td><td>Enter the appropriate two-digit collective bargaining unit code.</td></tr>
<tr><td><u>28</u><br>Agency Name</td><td>Enter the agency's name (do not abbreviate).</td></tr>
<tr><td><u>29</u><br>Payroll Office Code</td><td>Enter the appropriate code, referring to the Payroll Office Code section for a complete listing.</td></tr>
<tr><td><u>30 and 31</u><br>Agency and Unit Code</td><td>Enter an employer's three-digit agency and unit code (where applicable).</td></tr>
<tr><td><u>32</u><br>Signature of Health Benefits Officer<br>(required)</td><td>Signature of authorize Health Benefits Officer or assistant (Signature must be legible).</td></tr>
<tr><td><u>33</u><br>Date Received in Employing Office</td><td>The employing office where an employee receives his or her lowest level of supervision (local timekeeper or attendance clerk).</td></tr>
<tr><td><u>34</u><br>Phone Number</td><td>Enter the public phone number of the Health Benefits Officer or assistant who is the contact for an enrollment document.</td></tr>
</table>

# Health Benefits *Continue*

**Health Benefit Forms Completion** Continue

**Instructions for completing HBD 12**

| | |
|---|---|
| **35**<br>***Remarks*** | Use this section to enter additional information pertinent to the enrollment action and in numbering multiple documents.<br>When there are multiple documents, please number them 1/4, 2/4, etc.<br><br>You can also use this box to:<br>• List completed hours for a PI employee<br>• Certify an HBD-40 is on file for a Parent-Child Relationship dependent addition<br>• Explain coordination of coverage between family members<br>• Verify a family member's eligibility<br>• Explain any special circumstances |

**Affordable Care Act (ACA)**

Refer to the ***"Appointment***" section of the Attendance Clerk for more information regarding ACA.

**Dependent Eligibility Verification Checklist (CalHR Form 781)**

Employees are required to complete this form when adding dependents to health or dental coverage, as well as vision coverage processed through OHR and when an employee annually recertifies their parent-child relationship with enrolled dependents.

Employees may be held accountable if any documentation is determined to be inaccurate or fraudulent or for failure to notify OHR of changes to dependent eligibility.

Refer to the ***"Appointment***" section of the Attendance Clerk for more information regarding Dependent Eligibility.

**HIPAA or Late Enrollment**

If an employee declines or cancels enrollment for themselves or their dependents and do not qualify for the special enrollment exceptions, the employee (or the dependents) have limited rights to enroll in the future. Employees will either have to wait for 90 days or until the next CalPERS Open Enrollment period. The earliest effective date of enrollment will be the first of the month following the 90-day waiting period or the January 1 after the Open Enrollment period.

Refer to www.dhcs.ca.gov for more information regarding the Health Insurance Portability and Accountability Act (HIPAA).

# Health Benefits *Continue*

**Life Events (Permitting Events)**

When certain life events, circumstances or permitting events occur, employees are entitled or may require to make special enrollment updates within 60 days of the event. It is the responsibility of each department to inform employees of the requirements for making changes to their enrollment. The rules governing the changes vary by time limits, therefore, it is the employee's responsibility to advise and report changes to their AC as soon as possible after the event occurs. There are voluntary, mandatory and administrative additions/deletions that may occur based on the type of event. This means the **event must occur first** before the employee can file a change to their plan. CalPERS have identified Health Enrollment Reason Codes for specific events as well as effective date methods that apply to specific reasons (events); below are a few reason codes, for additional codes refer to: https://www.calpers.ca.gov/docs/circular-letters/2004/600-169-04-attach6.pdf

## HEALTH ENROLLMENT REASON CODES

| NEW ENROLLMENT | | | |
|---|---|---|---|
| REASON CODE | REASON DESCRIPTION | EVENT DATE | EFFECTIVE DATE METHOD* |
| 100 | New Employee | Date of appointment | 2 |
| 101 | Late or Loss of coverage (Employee) | Date other coverage ends | 2 |
| 102 | New enrollment after Reinstatement from Retirement | Date of appointment | 2 |
| 103 | Return from Military Leave | Date employee returns to work | 2 |
| 104 | New Enrollment for Employee during *Open Enrollment* | September 1st | 4 |
| 105* | New Enrollment for Retiree during *Open Enrollment* | September 1st | 4 |
| 106 | New State Permanent Intermittent (PI) Employee | July 1st or January 1st | 9 |
| 107 | New State Permanent Intermittent (PI) Employee Off Pay Status during initial 60-day enrollment period. | Date of return to pay status | 2 |
| 108 | Employee enrolling in their own CalPERS health plan after deletion as a dependent from a CalPERS health plan. | Date dependent coverage terminates | 2 |
| 109* | Retiree enrolling in their own CalPERS health plan after deletion as a dependent from a CalPERS health plan. | Date dependent coverage terminates | 2 |
| 110* | New enrollment for Survivor | Date of request to enroll | 2 |
| 111 | New enrollment for Employee Off Pay Status during Open Enrollment Period. | Date of return to pay status | 6 |

# Health Benefits *Continue*

**Life Events (Permitting Events)** Continue

EFFECTIVE DATES

| EFFECTIVE DATE NUMBER | EFFECTIVE DATE METHOD DESCRIPTION |
|---|---|
| 1 | 1st day of the month following the Event Date (Mandatory Event) or HBO Received Date (Permissive). |
| 2 | 1st day of the month following the HBO Received Date if within 60 days of the Event Date. If HBO Received Date is beyond the 60th day, the effective date is the 1st day of the month following a 90 day waiting period from the HBO Received Date (Permissive Event). |
| 3 | Administratively determined. |
| 4 | Open Enrollment effective date (January 1 of contract year). |
| 5 | Special Open Enrollment effective date determined by CalPERS. HBO Received Date must be within special enrollment dates established by CalPERS. |
| 6 | 1st day of the month following HBO Received Date or most recent Open Enrollment effective date, whichever is latest. |
| 7 | 1st day of the 2nd month following the Event Date. |
| 8 | 1st day of the month following HBO Received Date if within 60 days of the Contract Date. If HBO Received Date is beyond the 60th day, the effective date is the 1st day of the month following a 90 day waiting period from the HBO Received Date (Permissive Event). |
| 9 | State Permanent Intermittent Employees (PIs): 1st day of the month following the HBO Received Date if within 60 days of the Event Date. If HBO Received Date is beyond the 60th day, the effective date is the 1st day of the month following 90 days from the HBO Received Date. |

If an employee moves out of their health plan's service area, they must change plans. Until they make the change, the employee's previous health plan may limit coverage to emergency or urgent care only. When an employee moves, employees may submit their health plan change up to 60 days after the move. The effective date of the change will be the first of the month following the date Personnel receives the completed HBD 12.

### Voluntary Permitting Events

Voluntary additions/deletions not initiated by the employee within 60 days from the permitting event date may be processed only during the next open enrollment period.

Qualifying voluntary permitting events include:

- Enrollment of a new dependent(spouse, domestic partner and/or stepchild) as a result of marriage or domestic partnership registration
- Birth or adoption of a child, or placement of a child for adoption
- A court order that requires the employee
- to provide coverage for a spouse, domestic partner, or minor child
- Adding a spouse, certified domestic partner and/or dependents due to the cancellation of coverage under another CalPERS health plan or private plan. In this instance, the employee will need to request enrollment within 60 days of the date the other coverage ends and provide OHR with proof that it has ended.
- Adding a dependent due to a change in custody and/or acquiring an economically dependent child.
- Deleting a spouse or domestic partner who ceases to live in the household (not COBRA eligible) (may not re-enroll until next open enrollment period).
- Deleting a dependent who obtains other group coverage (non-State sponsored).

# Health Benefits *Continue*

### Mandatory Deletions

Dependents must be deleted as follows:

- Divorced spouse must be deleted from coverage even if the divorce settlement requires the employee to provide coverage for the spouse. The State is not required to provide coverage for an ex-spouse, however, COBRA (Consolidated Omnibus Budget Reconciliation Act) must be offered.
- Termination of a Domestic Partnership. (Employee must provide copy of notice of termination of the domestic partnership to the personnel office and COBRA must be offered to the terminated domestic partner.)
- Death of a dependent.
- Dependent child reaches age 26 and is not disabled.
- Dependent goes into military.
- Dependent no longer economically dependent/change of custody.
- Dependent enrolled but not eligible.
- Dependent dual or split covered.

### Administrative Deletions

The following deletions are processed administratively by the Personnel Specialist; AC's must notify the Personnel Specialist if they become aware of situations that apply. The Personnel Specialist is responsible for notifying the employee of administrative deletions.

- Dependents who reach age 26 and are not disabled.
- Employees and/or dependents enrolled but not eligible or dual/split coverage exists. Delete retroactive to the effective date, the employee is responsible for any costs for services that were performed on him/her or any ineligible dependent.
- Employees that are enrolled but not eligible
    - The employee must be notified regarding this change and will not be allowed to enroll in a plan until the next scheduled open enrollment.
- Death of a spouse, domestic partner or child upon receipt of a death certificate. (Must provide OHR the death certificate)

### Disenrollment of Ineligible Family Members

It is against the law to continue enrollment of an ineligible family member. If an employee continues to do so, they may have to pay all costs incurred by the ineligible person during the ineligibility period.

State law limits the health premium reimbursement period to six months for certain life-changing events.

> For example, if an employees divorce or dissolution occurred in 2009, yet they did not report it until 2012, the former spouse or registered domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution. The health premiums will be adjusted for a period of no more than six months from the date Personnel receives copies of supporting documentation.

# Health Benefits *Continue*

### Dependent Vesting

Dependent health care vesting requires new employees who have never had State health benefit eligibility receive a reduced employer health benefits contribution toward dependent health coverage during the first 12 or 24 months of service. The employer contribution may change each plan year and is **determined by the bargaining contract**.

All new employees are required to acknowledge receipt of benefit information, including information regarding "dependent health care vesting for new to state employees" by signing the Initial Notification of Benefits form located in the Attendance Clerk Toolkit: http://www.dgs.ca.gov/ohr/Resources/Toolkits/AttendanceClerkToolkit.aspx

Dependent health care vesting provides new employees a reduced employer health benefits contribution toward dependent health coverage during the first 12 or 24 months of service.

New employees in Bargaining Units 1, 3, 4, 11, 14, 15, 17, 20, and 21 not previously eligible for health benefits under State civil service, receive:

- 75% of the employer contribution for dependent health coverage during the first 12 months of service.
- After completing 12 months of service, new employees receive the full employer contribution for dependent health coverage.

New employees in Bargaining Units 2, 7, 10, 12, 13, 16, 18, and 19 not previously eligible for health benefits under State civil service, receive:

- 50% of the employer contribution for dependent health coverage during the first 12 months of service.
- 75% of the employer contribution for dependent health coverage during months 13 through 24.

After completing 24 months of service, new employees receive the full employer contribution for dependent health coverage

### New Employee With Prior State Services

New employee with prior state service must meet all of the following criteria to be exempt from dependent vesting:

- Employees previous appointment date was prior to *January 1, 2007* if you are in Bargaining Unit 1, 3, 4, 10, 11, 12, 13, 14, 15, 16, 17,18, 19, 20, or 21; or prior to *July 1, 2006* if you are in Bargaining Unit 2 or 7;
- Employee's previous appointment was a State civil service appointment (and not a UC or CSU appointment).
- Employee was eligible for State health benefits. It doesn't matter whether or not they actually enrolled in health benefits as long as they were eligible to enroll.

# Health Benefits *Continue*

### Dependent Health Care Vesting Period Begins

The 12 or 24-month vesting period begins with the month the employee are first eligible for State health benefits. The vesting period is a continuous 12 or 24 months unless the employee permanently separates from State service. Upon reinstatement, following a permanent separation, the employee must serve the remainder of their vesting period.

For Permanent Intermittent (PI) employees, the 12 or 24 month vesting period begins following the completion of a control period, at that point the PI becomes eligible for health benefits. For example, if a PI meets the required hours in the July 1 through December 31 control period, they first become eligible for health benefits on February 1. The vesting clock starts on February 1 and continues to run unless the PI permanently separates or loses health eligibility.

### Transfer From A Unit Without Vesting To One With Vesting

Health Care Vesting would not apply if the employee is already receiving 100% of the employer health contribution for their dependents; they remain fully vested no matter how long they have worked for the State.

### Transfer From A Unit With Vesting To One Without Vesting

An employee will begin receiving 100% of the employer health contribution for dependents when you're appointed to the new bargaining unit. Please refer to the appropriate collective bargaining agreement for the specific criteria for determining if an employee is subject to dependent vesting.

### Domestic Partners

Domestic partners may be added to the health/dental/vision plan. The law requires the following for enrollment:

- The employee must register with the Secretary of State. The form may be found through the Secretary of State website: http://www.ss.ca.gov/registries/domestic-partners-registry/
    - For same sex domestic partnership, it must be between two people who are at least 18 years of age.
    - For opposite sex domestic partnership, one of the partners must be at least 62 years of age and the other must be at least 18 years of age.
    - The enrollee must provide a copy of the Declaration of Domestic Partnership.

Enrollment must be done within 60 days of the Registration of Domestic Partnership. If not done within 60 days, the employee must wait for open enrollment.

*Note:* The employee must cancel coverage of domestic partner when the domestic partnership terminates or when the domestic partners no longer share a common residence. Upon termination of the domestic partner's coverage, coverage for children of domestic partners, enrolled as economically dependent children under the domestic partnership, must also be terminated.

# Health Benefits *Continue*

### Imputed Tax Liability

When an employee who adds a domestic partner to their health, dental and vision, they will have imputed tax liability unless the domestic partner is being claimed as a dependent for Federal Income Tax purposes.

To remove the imputed tax liability:

- The Affidavit for Domestic Partners Being Claimed As Economic Dependents form CalHR 680 must be completed and signed by the employee.
- Return to PTU.
- Failing to return the CalHR 680 will incur more income tax withhold.

CalHR 680 form can be found through the CalHR website: http://www.calhr.ca.gov

### Benefit Calculator

To determine how much will be deducted from the employees pay warrant, based on the health, dental, and vision plans chosen utilize the benefit calculator.

http://www.calhr.ca.gov/Pages/Benefits-Calculator.aspx

# Health Benefits *Continue*

## Sample of CalHR 680

State of California
**AFFIDAVIT FOR DOMESTIC PARTNERS BEING CLAIMED AS ECONOMIC DEPENDENTS**
CalHR-680 (Revised 8/13/2013)

| Employee Name (First, MI, Last) | Social Security Number | Tax Year |
|---|---|---|
| _____ | _____-____-_____ | |

**Please print in ink or type**

***Please Read This Affidavit Carefully***

SAMPLE

State law and/or collective bargaining agreements permit the eligibility of domestic partners for the purposes of enrollment into a state-sponsored dental plan and health plan. When a State employee adds a domestic partner, the employee will have imputed tax liability based on the amount of the increase in State contribution to benefits paid for the domestic partner, unless the domestic partner is claimed as a dependent for Federal Income Tax purposes as authorized by the Internal Revenue Service.

In order to remove the imputed tax liability when enrolling a domestic partner into a State dental plan and/or health plan, California Department of Human Resources requires that this affidavit be completed and signed by the State employee.

Please complete and sign this affidavit and return it to your personnel office. Failure to return this document may cause you to incur more income tax withholding based on an increase in taxable income.

**SECTION A – EMPLOYEE STATEMENT – READ CAREFULLY**

Please carefully read the following paragraph and print your name and that of your domestic partner in the appropriate areas:

I, _____, under penalty of perjury declare my domestic partner, _____ as a dependent for the purposes of my Federal Income Taxes. I further affirm under penalty of perjury that should I no longer declare my domestic partner as a dependent for tax purposes, that I will immediately notify the State in writing of this fact. I understand that if I do not notify the State in writing immediately of the change in dependency status for my domestic partner, that I may be held liable for any taxes due based on when the dependency ended. By signing this document I also agree to permit the State upon request of an authorized representative of the California Department of Human Resources or the State Controller' Office or their designee, full access to my tax records, domestic partner filing documents and/or any other supporting documentation as needed by the State to verify dependency for Federal Income Tax purposes.

**SECTION B – SIGNATURES**

| EMPLOYEE SIGNATURE REQUIRED | DATE: _____/____/_____ |
|---|---|

FOR EMPLOYING AGENCY USE ONLY Affidavit received on ___/___/_____, by _____

AGENCY NAME: _____

# Health Benefits *Continue*

**Disabled Children Over Age 26**

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. The employee is require to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form;

Questionnaire for Disabled Dependent Benefit Form (HBD-98),

The physician must complete the Medical Report

Medical Report for the CalPERS Disabled Dependent Benefit Form (HBD-34)

Prior to enrollment, both documents (HBD 98 and HBD 34) must be submitted to OHR to request approval from CalHR.

The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 60 days before and ending 60 days after the child's 26th birthday (member and dependent currently enrolled), or
- Within 60 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

Upon certification of eligibility, the dependent's coverage must be continuous and without lapse. The employee will be required to submit an updated questionnaire and medical report for re-certification periodically, upon request.

*Note:* If the disabled child has a Social Security- approved disability, you must provide CalPERS with a copy of his or her Medicare card.

# Health Benefits *Continue*

## Disabled Children Over Age 26 Continue

### Sample of Questionnaire for Disabled Dependent Benefit Form - HBD 98

CalPERS

**Health Account Services**
P.O. Box 942715
Sacramento, CA 94229-2715
**(888) CalPERS** (or 888-225-7377)
TTY (877) 249-7442
Fax (800) 959-6545

**MEMBER QUESTIONNAIRE for the CalPERS DISABLED DEPENDENT HEALTH BENEFIT**

Member: Please complete all items. Incomplete forms will be returned causing a delay in benefits. CalPERS will determine eligibility upon receipt of this form and the physician's **MEDICAL REPORT for the DISABLED DEPENDENT BENEFIT.**

SAMPLE

| PART A: EMPLOYEE/ANNUITANT INFORMATION: | DEPENDENT INFORMATION: |
|---|---|
| **Name:** _____ | **Name:** _____ |
| **Social Security Number (SSN):** _____-_____-_____ | **Social Security Number (SSN):** _____-_____-_____ |
| **Address:** _____ | **Address:** _____ |
| **Telephone:** (____) _____ | **Date of Birth:** _____ |

**PART B:** Please provide the following information about the dependent who is seeking initial or continued enrollment or recertification in the health plan under the disabled dependent benefit. For purposes of this benefit, a person is considered disabled if the person is incapable of self-support (i.e., incapable of any substantial gainful activity) as a result of a physical or mental disabling injury, illness or condition. Mail this completed form to the above address.

| *MEMBER QUESTIONNAIRE* | | | |
|---|---|---|---|
| | | | **Health Insurance** |
| **1.** | | | Is the dependent entitled to: |
| | **Yes** | **No** | Medicare Part A (hospital care)? (If yes, attach a copy of the dependent's Medicare card.) |
| | **Yes** | **No** | Medicare Part B (medical care)? (If yes, attach a copy of the dependent's Medicare card.) |
| | **Yes** | **No** | Other insurance? (If yes, specify the plan name and type of coverage.) |
| | | | **Income and Support** |
| **2.** | **Yes** | **No** | Is the dependent economically dependent upon you for his or her support? |
| | **Yes** | **No** | I claim the child as my dependent for income tax purposes. |
| **3.** | | | Is the dependent entitled to receive: |
| | **Yes** | **No** | Social Security Disability Insurance (SSDI)? If yes, as of what date? _____ |
| | **Yes** | **No** | Supplemental Security Income (SSI)? If yes, as of what date? _____ |
| | | | **Additional Eligibility Questions** |
| **4.** | **Yes** | **No** | Is the dependent working? |
| | **Yes** | **No** | Is the dependent incapable of self-support because of a physical or mental disability? |
| | | | If yes, what age did the dependent become physically or mentally disabled? _____ |

**PART C: CERTIFICATION:**
*I hereby certify under penalty of perjury, that information provided by me is true and correct to the best of my knowledge. I also agree to provide supporting documentation such as, but not limited to, tax returns, statement of financial liability, or any other documents, when requested by my employer or CalPERS.*

_____ _____
Employee/Annuitant Signature Date

HBD-98 Rev 1/14

# Health Benefits *Continue*

## Disabled Children Over Age 26 Continue

### Sample of Medical Report for the CalPERS Disabled Dependent Benefit Form (HBD-34 page 1)

CalPERS

**Health Account Services**
P.O. Box 942715
Sacramento, CA 94229-2715
888 CalPERS (or 888-225-7377)
TTY (877) 249-7442
Fax (800) 959-6545

**MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT**

***COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.***

| MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A: MEMBER INFORMATION | DEPENDENT INFORMATION |
|---|---|
| **NAME:**_____ | **NAME:**_____ |
| **SOCIAL SECURITY NUMBER (SSN):**_____ | **SSN:** _____ |
| **ADDRESS:** _____ | **ADDRESS:**_____ |
| **TELEPHONE** ( ) _____ | **DATE OF BIRTH:**_____ |

SAMPLE

**PART B: DEPENDENT AUTHORIZATION:** *The dependent or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:*

I hereby authorize my attending physician_____to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____
Signature of Dependent **OR** Date Signed

_____ _____
Person authorized to act on his/her behalf Relationship to the dependent

**PHYSICIAN PART C:** *The physician is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.*
***Please DO NOT send information copied directly from the patient's medical record at this time.***

**Dear Doctor:**
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

| ***Medical Report*** | |
|---|---|
| **1.** | I attended the patient for the current disabling medical problem or condition from _____to _____; At intervals of _____. I last examined the patient on _____. |
| **2.** | Medical History (related to disability): Date of Disability Onset:_____ |
| **3.** | Diagnosis (REQUIRED): _____<br>ICD-9 Disease Code, Primary (Required) : _____<br>ICD-9 Disease Code(s), Secondary : _____<br>DSM IV Code(s) (if any) : _____ |
| **4.** | Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings) |
| **5.** | Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability):<br>☐ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.) |

# Health Benefits *Continue*

## Sample of Medical Report for the CalPERS Disabled Dependent Benefit Form (HBD-34 page 2)

MEMBER: _____ DEPENDENT NAME: _____
SSN: _____ SSN: _____

| *Medical Report* | |
|---|---|
| 6 | Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self support.<br>**Mobility Skills** ____walking ____sitting ____standing ____lifting ____bending<br>**Self Care Skills** ____feeding ____bathing ____toileting ____dressing<br>**Sensory Skills** ____hearing ____sight ____speech ____touch<br>**Cognitive Skills** ____judgment ____memory ____planning/follow through ____thinking/processing information |
| 7. | Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting: |

SAMPLE

**PART D: Medical Certification of Disability and Incapacity of Self Support:** For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
   _____NO, the patient does NOT have a physically of mentally disabling injury, illness or condition.
   _____YES (Please answer Question 2.)

2. In your medical or psychiatric opinion, please select **A**, **B**, or **C**:
   _____**A**. The patient's current disability DOES NOT render him or her incapable of self-support.

   _____**B**. The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
   (projected DATE— mm / yy)
   *If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur.*
   *Please DO NOT leave the DATE blank. Answers such as "indefinite" or don't know" will not suffice.*

   _____**C**. The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a _____. _____
(Type of Physician) (Specialty, if any)
licensed to practice by the State of _____.

*PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:*

_____ _____
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

_____ _____
LOCAL ADDRESS STATE LICENSE NUMBER

_____ (_____)_____
CITY STATE TELEPHONE NUMBER

_____ (_____)_____
DATE FAX NUMBER

**PART E: CalPERS USE ONLY:**

_____Claim approved for enrollment through _____ _____
DATE (for next review) REVIEWED BY

_____ Claim rejected. _____
DATE

HBD-34 Rev 6/13

# Health Benefits *Continue*

**Dependents in a Parent-Child Relationship**

A child other than an adopted, step or recognized natural child up to age 26 may be added to the employee's health plan if both of the following criteria are met:

- they have assumed a parent-child relationship
- they are considered the primary care parent

The employee has 60 days from the date they obtained custody of the child to enroll him or her on their health plan. Prior to enrollment of a dependent that is in a parent-child relationship, the employee must complete and submit An Affidavit of Parent – Child Relationship Form (HBD-40). The employee will need to provide supporting documentation based on the dependent's age such as court records, school records, tax returns, or additional proof that a parent-child relationship exists. A parent-child relationship must be certified at the time of enrollment for each child and annually thereafter up to age 26.

- Employees will receive reminder notices from CalPERS prior to their annual re-certification period.

Coverage will become effective the first day of the month following the date OHR receives the *Health Benefits Plan Enrollment* form and supporting documents.

**Supporting Documentation for Dependents Under Age 19**

Required supporting documentation for dependents under age 19 includes:

- A copy of the first page of the employees' income tax return from the previous tax year listing the child as a tax dependent.
- In lieu of a tax return, for a time not to exceed one tax filing year, employees may submit other documents that substantiate the child's financial dependency upon them, including the following:
    - Current legal judgments or court documents showing the employees legal parental status or duties/guardianship over the child
    - Bank, credit card, tuition or insurance statements or payments
    - School records
    - Bills or mail indicating common residency with the child

**Supporting Documentation for Dependents From Age 19 to Age 26**

Required supporting documentation for dependents from age 19 up to age 26 includes:

- A copy of the first page of the subscriber's income tax return from the previous tax year listing the child as a tax dependent, **OR**
- Other suitable documentation, that substantiates that the child is financially dependent upon the subscriber provided that the child:
    - Either lives with the subscriber for more than 50 percent of the time, or is a full-time student, **AND**
    - Is dependent upon the subscriber for more than 50 percent of the child's support.

# Health Benefits *Continue*

**Supporting Documentation for Dependents From Age 19 to Age 26** Continue

The following table provides examples of required supporting documentation used to establish residency and financial dependence:

| Requirement Type | Supporting Documentation Age 19-26 |
|---|---|
| Residency (more than 50% of the time) | • School records indicating full-time status, or<br>• Bills or mail in the child's name listing the same address as the subscriber, such as:<br><br>School correspondence<br>Employment correspondence<br>Bank statements or correspondence<br>Vehicle registration, insurance bills/statements<br>Credit card bills/statements<br>Rental/lease agreements |
| Financial Dependence (more than 50% of child's support) | • Recurring bills or statements of account, identified as other suitable documentation, paid by the employee on behalf of the child, such as:<br>− Tuition payments<br>− Cell phone bill payments<br>− Auto loan payments<br>− Auto insurance payments<br>− Credit card payments<br>− Bank statement, custodian account, cancelled checks, or other evidence of financial dependence. |

**Note:** When submitting copies of tax documents, household bills or account statements, employees should blackout sensitive information, such as driver's license numbers, and bank, credit card, and other financial or policy account numbers. Also, mark each document "Not for Official Use."

**Submitting Affidavit and Supporting Documents**

Prior to submission to OHR provide the employee a copy of the affidavit for their record. The Personnel Specialist will retain the original in the employee's OPF.

## Retirees

Will submit their Affidavit and supporting documentation to CalPERS.

# Health Benefits *Continue*

## Dependents in a Parent-Child Relationship Continue

### Sample of Affidavit of Parent–Child Relationship Form (HBD-40) Front

CalPERS

P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or 888-225-7377)|Fax (800) 959-6545
www.calpers.ca.gov

**Affidavit of Parent-Child Relationship**

The Public Employees' Medical and Hospital Care Act (PEMHCA), allows employees and annuitants to enroll family members in the CalPERS Health Benefits Program. Pursuant to Title 2, California Code of Regulations, 599.500(o), a "parent-child relationship" (PCR) is established when you intentionally assume parental status or duties over a child who is not your adopted, step, or recognized natural child, and meet specific enrollment criteria.

SAMPLE

As specified in Section 599.500(o) and outlined below, you are required to substantiate a financial responsibility upon initial enrollment and annually thereafter up to the child reaching age 26. You must submit a separate PCR Affidavit for each PCR dependent.

**Note:** Spouses of your adopted, step, and recognized natural children do not qualify for CalPERS health coverage under any circumstances.

**SECTION A: Employee/Annuitant Information**

1. Name *(First)* *(M.I.)* *(Last)*
2. Social Security Number
3. Date of Birth (mm/dd/yyyy)
4. Date you assumed the primary parental status or duties for the PCR dependent: (mm/dd/yyyy)
5. Relationship to the PCR dependent:

**SECTION B: PCR Dependent Information**

6. Name *(First)* *(M.I.)* *(Last)*
7. Social Security Number
8. Date of Birth (mm/dd/yyyy)
9. Address *(if different from yours): (Street)* *(City)* *(State)* *(ZIP)*

**SECTION C: Supporting Documentation Requirements**

10. As evidenced by your selection below, you are certifying you have assumed parental status or duties and will provide the required supporting documentation for your PCR dependent with this Affidavit.

| | |
|---|---|
| **For a PCR Dependent Under Age 19:**<br>• A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent.<br>• **In lieu of a tax return, for a time not to exceed one tax filing year,** you may submit other documents that substantiate the child's financial dependence upon you, including, but not limited to: current legal judgments/court documents showing the subscriber's legal parental status or duties/guardianship over the child; bank, credit card, tuition or insurance statements/payments; school records; bills or mail indicating common residency with the dependent (collectively referred to as "Other Suitable PCR Documentation"). | ☐ Yes<br>☐ No |
| **For a PCR Dependent From Age 19 Up to Age 26:**<br>• A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent, **OR**<br>• Other Suitable PCR Documentation, as mentioned above, that substantiates that the child is financially dependent upon you provided that the child:<br>o Either lives with you for more than 50 percent of the time, or is a full-time student, AND<br>o Is dependent upon you for more than 50 percent of the child's support | ☐ Yes<br>☐ No |

HBD-40 (Rev. June 2015)

# Health Benefits *Continue*

## Dependents in a Parent-Child Relationship Continue

### Sample of Affidavit of Parent–Child Relationship Form (HBD-40) Back

**SECTION D: Signature of Employee/Annuitant**

11. I recognize this affidavit is a legally binding document. I accept full responsibility to notify my employer or CalPERS of any changes pertaining to this PCR. I further understand the provision of California Government Code 20085, which states in part:
    (a) It is unlawful for a person to do any of the following:
        (1) Make, or cause to be made, any knowingly false material statement or material representation, to knowingly fail to disclose a material fact, or to otherwise provide false information with the intent to use it, or allow it to be used to obtain, receive, continue, increase, or reduce any benefit administered by this system.
        (2) Present, or cause to be presented, any knowingly false material statement or material representation for the purpose of supporting or opposing an application for any benefit administered by this system.

SAMPLE

**I hereby certify under penalty of perjury, that the information I have provided is true and correct to the best of my knowledge.** I also agree to provide **all** supporting documentation requested by my employer or CalPERS. I understand that each PCR dependent must be certified upon initial enrollment and annually thereafter up to age 26. I also understand that certification includes submission of this Affidavit **and** the required supporting documents.

Employee/Annuitant Signature _____ Date _____

**Important!**
**Active Employees:** Return this Affidavit and the required supporting documents to your employer.
**Retirees:** Return this Affidavit and the required supporting documents to CalPERS.

**SECTION E: For Employer Use Only**

12. I hereby certify under penalty of perjury as follows: That I am a duly appointed, qualified, and acting officer of the following agency: _____

☐ I have reviewed the above affidavit and verified the identity of the employee or annuitant submitting this affidavit.

☐ I recommend enrolling/re-certifying this PCR dependent based on the information provided and attached documentation [per CCR §599.500(o)].

☐ I do not recommend enrolling/re-certifying this PCR dependent based on the information provided and/or lack of supporting documentation [per CCR §599.500(o)].

☐ Enroll ☐ Recertify ☐ Do not enroll ☐ Do not recertify

Human Resources Manager Name (Print) _____ Human Resources Manager Signature _____ Date _____

Health Benefits Officer Name (Print) _____ Health Benefits Officer Signature _____ Date _____

HBD-40 (Rev. June 2015)

# Health Benefits *Continue*

**Consolidated Benefits (CoBen)/Cash Options**

Refer to the Flex-Elect/CoBen Section of the Attendance Clerk Manual.

**CalPERS Supplement to Medicare Health Plans**

Medicare is a federal health insurance program that covers individuals age 65 and older. Medicare also covers some individuals under age 65 with Social Security-qualified disabilities and with End-Stage Renal Disease (ESRD is permanent kidney failure requiring dialysis or a kidney transplant).

The Social Security Administration (SSA) is the federal agency responsible for Medicare eligibility determination, enrollment, and premiums. The Centers for Medicare & Medicaid Services (CMS) regulates the Medicare program. The CMS publishes *Medicare & You,* a handbook that provides general information about Medicare. Employees can view or download this publication at www.medicare.gov. Different parts of Medicare cover specific services for employees who meet certain conditions. The following section provides basic information about the parts of Medicare, which will help employees understand eligibility guidelines and enrollment in a CalPERS health plan.

For more information about the various parts of Medicare, Medicare premiums, enrollment, and eligibility issues, contact the SSA at (800) 772-1213 or TTY (800) 325-0778, or visit their website at www.ssa.gov.

Depending on where an employee resides or works, one or more of the following Medicare health plan types may be available.

- Health Maintenance Organization (HMO) Supplement to Medicare Plans
- Health Maintenance Organization (HMO) Medicare Managed Care Plans (Medicare Advantage Plans)
- •Preferred Provider Organization (PPO) Supplement to Medicare Plans
- •Exclusive Provider Organization (EPO) Supplement to Medicare Plan (for members in certain California counties)

**Certifying Medicare Status**

A notice will be sent from CalPERS four months prior to the employee's 65th birthday month. This notice provides information on CalPERS requirements for continuing health coverage. If the employee has retired or have initiated the process of retiring from active employment, they will also receive a *Certification of Medicare Status*.
.

# Health Benefits *Continue*

**Certifying Medicare Status** Continue

In order for the employee to continue their CalPERS health coverage, they must certify their Medicare status. The employee will need to complete the *Certification of Medicare Status* form and return it to CalPERS with the proper documentation certifying one of the following choices:

- Enrollment in Medicare Parts A and B (submit a copy of Medicare card or SSA documentation)
- Ineligible for Medicare either in their own right and/or through the work history of a current, former, or deceased spouse (submit SSA documentation)
- Deferred enrollment in Medicare Part B due to the employee's or the employee's spouse's employment (submit proof of active group health insurance through current employer)

If the employee is retired, and they do not return the *Certification of Medicare Status* form and/or copies of your supporting documentation to CalPERS *by the beginning of your birth month.* Failure to do so will result in a notice of cancellation informing the employee their health coverage for themselves and all enrolled dependents will be automatically canceled the first day of the month after they turn 65.

For assistance completing the form, contact CalPERS toll free at 1-888-225-7377).

***Note:*** *CalPERS Medicare health plan will become effective on the employee's Medicare effective date or the first day of the month following CalPERS receipt of the Certification of Medicare Status form, whichever is later.*

**Ineligible for Medicare**

An employee who is ineligible for Medicare, they must indicate on the *Certification of Medicare Status* form the reason for ineligibility:

- Did not work in employment covered by Social Security/ Medicare programs
- Do not have 40 quarters in Social Security/Medicare-covered employment
- Do not qualify through the work history of a current, former, or deceased Spouse

The employee is require to submit to CalPERS the *Certification of Medicare Status* form, a copy of the Social Security statement or letter from the SSA indicating they are not eligible for Medicare based on their work record and/or the work history of a current, former, or deceased spouse. The employee may remain in a Basic health plan unless they later become eligible for Medicare Part A at no cost.

# Health Benefits *Continue*

### Not Qualified for Medicare Part A

An employee who does not qualify for premium-free Medicare Part A based on their Social Security/Medicare work record or the record of their current, former, or deceased spouse, may remain in a CalPERS Basic health plan. If the employee later qualifies for Medicare Part A at no cost, they must enroll in Medicare Part B and in a CalPERS Medicare health plan.

***Note**: An employee who is not currently eligible for premium-free Medicare Part A in their own right, they may be eligible for it when their spouse turns 62. To confirm eligibility through a spouse, contact the SSA at (800) 772-1213 or TTY (800) 325-0778, or visit their website at www.ssa.gov.*

### Deferred Enrollment in Medicare Part B

The employee or their spouse can defer enrollment in Medicare Part B if either of the following apply:

- are still working and have active employer group health coverage
- their spouse is still working and the employee is covered under his or her active employer group health coverage

If deferring enrollment in Medicare Part B, the employee must indicate this on the *Certification of Medicare Status* form. Return the form to CalPERS, and provide proof of active group health insurance through the current employer. The employee will remain in a CalPERS Basic health plan until retirement or until the employee loses their employer group health coverage.

### Cancellation of CalPERS Health Coverage for Failure to Certify Medicare Status

CalPERS Basic health plan coverage will be canceled if the Medicare status is not provided to CalPERS. To request re-enrollment through an Administrative Review process within 90 days of the date the coverage is canceled by writing to:

CalPERS Health Account Services
Medicare Administration
P.O. Box 942714
Sacramento, CA 94229-2714

A determination will be sent within 60 days informing the employee if their coverage will be reinstated. If the coverage is not reinstated, the employee may re-enroll during CalPERS annual Open Enrollment period by providing a completed *Certification of Medicare Status* form with the required supporting documentation.

# Health Benefits *Continue*

### CalPERS Health Plans and Medicare Part D

An Employee who is eligible for Medicare is eligible for Part D. However, CalPERS Medicare health plans provide prescription drug coverage that is as good as–or better than–the standard benefits of Medicare Part D. In the fall of each year, either the health plan or CalPERS will send a *Notice of Creditable Coverage.* This notice is evidence that the employee is enrolled in a prescription drug plan. Keep the notices as proof of enrollment to avoid the Medicare Part D late enrollment penalty if needed to enroll in Medicare Part D at a later date. The employee may be assessed a monthly premium based on their income. This includes the Part D (Medicare prescription drug) coverage received from a Medicare Advantage Plan. The SSA will notify the employee to pay this premium. For further information contact the SSA toll free at (800) 772-1213 or TTY (800) 325-0778, or visit their website at www.ssa.gov.

### Do Not Enroll in a non-CalPERS Medicare Part D Plan

An employee cannot have prescription drug coverage under both Medicare and CalPERS. To continue CalPERS health coverage, do not enroll in a non-CalPERS Medicare Part D plan. If the employee  or their dependents are covered by CalPERS and another health plan that includes Medicare Part D prescription drug benefits, they must cancel the Part D coverage in order to enroll in (or continue enrollment in) a CalPERS Medicare health plan.

# Health Benefits *Continue*

### Open Enrollment

Open enrollment is scheduled annually during the month of September through mid-October. Eligible employees can:

- Change their CalPERS health plan
- Enroll in a CalPERS health plan if do not currently have CalPERS health coverage
- Drop existing CalPERS health coverage
- Add new dependents to their health coverage
- Delete dependents from their health coverage

Refer to the "***Open Enrollment***" *section* of the Attendance Clerk Manual for detailed information.

### Dependent Eligibility Verification Checklist

Refer to ***"Appointment Process"*** *section* of the Attendance Clerk Manual for detailed information.

### CalPERS Rescind Health Transactions

Employees have the ability to rescind health transactions when the effective date of the transaction occurs in the future.

For example, prior to January 1, of the next year or the effective date of all open enrollment transactions, if the employee decides they no longer want to change health plans, the PS may rescind the transaction within the myICalPERS system. Employees cannot select another health plan, but can rescind the Open Enrollment change and return to the original health plan.

### COBRA

Refer to Consolidated Omnibus Budget Reconciliation Act (COBRA) – CalHR (http://www.calhr.ca.gov/state-hr-professionals/Pages/benefits-administration-manual-cobra.aspx) and COBRA located in the Separation Section of the Attendance Clerk Manual for detailed COBRA information.

# Health Benefits *Continue*

### Direct Pay Option

Employees may continue coverage during off-pay status or while on temporary leave by paying the entire monthly health premium directly to the health plan. Employees are eligible for direct payment if:

• Take a leave of absence without pay
• Take temporary disability leave and do not use sick leave or vacation time
• Are waiting for approval of disability or “regular” service retirement
• Are waiting for approval of Non-Industrial Disability Insurance benefits
• Are suspended from their job
• Institute legal proceedings appealing a dismissal from their job
• Are a State Permanent-Intermittent employee eligible for health benefits, but are on non-pay status (Direct pay may only be elected through the end of the qualifying control period.)

To initiate direct payment, employees must complete a Direct Payment Authorization Form (HBD-21). Employees must submit requests for the direct payment option to the personnel office prior to the beginning of the leave, but no later than the last day of the month of coverage. **If employees do not elect the direct payment option during off-pay status, employee’s coverage must be canceled.** Employees can re-enroll when they return to pay status if they have sufficient earnings.

# Health Benefits *Continue*

**Direct Pay Option** Continue

**Sample of Direct Payment Authorization Form (HBD 21) Front**

CalPERS

**Health Account Services**
P.O. Box 942715
Sacramento, CA 94229-2715
**(888) CalPERS** (or 888-225-7377)
TTY (877) 249-7442
FAX (800) 959-6545

**Direct Payment Authorization Form (HBD-21)**

**PART A - EMPLOYEE INFORMATION**

| 1. SOCIAL SECURITY NUMBER | 2. NAME (FIRST) (MIDDLE) (LAST) |
|---|---|
| -- -- | |
| 3. HOME PHONE NUMBER ( ) | 4. HOME ADDRESS (STREET) (CITY) (STATE) (ZIP) (COUNTY) |

SAMPLE

**PART B - CARRIER PREMIUM INFORMATION**

| 5. DIRECT PAYMENT TO: (CARRIER NAME AND ADDRESS) | 5A. PLAN CODE & PARTY CODE |
|---|---|
| NAME: _____ | |
| STREET: _____ | 5B. GROSS PREMIUM |
| CITY: _____ | $ |
| STATE: _____ ZIP CODE _____ | |

5C. THE ABOVE PREMIUM IS PAYABLE TO CARRIER INDICATED, BEGINNING WITH PREMIIUM MONTH OF: _____ (MONTH) _____ (YEAR)

6. I agree to pay all premiums directly to the health plan carrier listed above by the specified due date(s) to cover the cost of enrollment as it is now or as it may be in the future. I understand that failure to pay premiums will result in suspension of my coverage. I also understand that even though I may not receive a bill from the carrier, I am still responsible for sending the payment to them and that no employer contribution will be made during the direct payment period.

EMPLOYEE SIGNATURE: DATE:

**PART C - REASON FOR DIRECT PAY**

| | | |
|---|---|---|
| 7. LEAVE OF ABSENCE ☐ | 8. SUSPENSION ☐ | 9. PERMANENT-INTERMITTNET (OFF PAY) ☐ |
| 10. ON WORKER'S COMP (ELECTED NOT TO SUPPLEMENT) OR CLAIM PENDING ☐ | 11. PENDING RETIREMENT ☐ | 12. 120-DAY DEATH BENEFIT (GC 19849.15) ☐ |

13. OTHER (INSUFFICIENT EARNINGS, PENDING NDI/SDI) PLEASE EXPLAIN: _____

**PART D - AGENCY INFORMATION**

| 14. NAME OF EMPLOYING AGENCY | 14A. CALPERS EMPLOYER ID | 14B. DIVISION ID | 14C. EMPLOYEE BARGAINING UNIT |
|---|---|---|---|
| | | | |

| 15. DATES OF ABSENCE (MM/DD/YYYY) (MM/DD/YYYY) | 16. LAST PREMIUM DEDUCTION PAY PERIOD |
|---|---|
| FROM: _____ TO: _____ | _____ (MM/DD/YYYY) |

17. SIGNATURE OF HEALTH BENEFITS OFFICER (HBO): DATE: PHONE NUMBER:

Rev 6/14 Original: Employee's Personnel File Copy: Employee

# Health Benefits *Continue*

## Direct Pay Option Continue

### Sample of Direct Payment Authorization Form (HBD 21) Back

SAMPLE

**Health Plan Direct Payment General Instructions**

**I. TYPES OF SITUATIONS THAT MAY BE ELIGIBLE FOR DIRECT PAY:**

- Leave of absence without pay.
- On temporary disability leave and do not use leave credits or supplementation.
- Pending approval of disability retirement or service retirement.
- Pending approval of Non-Industrial State Disability Insurance benefits.
- Suspended from your job or you institute legal proceedings appealing a dismissal from your job.
- State Permanent Intermittent employee eligible for health benefits but in a non-pay status.
- 120-day death benefit for eligible dependents enrolled on the date of employee's death.

**II. EMPLOYEES WHO DO NOT ELECT TO ENROLL IN DIRECT PAY ARE SUBJECT TO THE FOLLOWING:**

- Health insurance will be terminated.
- Employee must submit a Health Benefits Plan Enrollment form (HBD-12) to re-enroll in a health plan upon return to pay status.

**III. EMPLOYEES WHO ELECT TO ENROLL IN DIRECT PAY WHILE ON NON-PAY STATUS ARE SUBJECT TO:**

- It is the employee's responsibility to provide the carrier with a copy of the Direct Payment Authorization form (HBD-21) and all payments by the established due dates. Do not send this form to CalPERS.
- Payments must be received by the carrier by the 10th of each month.
- If the employee wishes to add or delete eligible dependents, they must submit a Health Benefits Plan Enrollment form (HBD-12) to their departmental Personnel Office and mail a copy to the carrier.
- The employee must contact their departmental Personnel Office if they wish to discontinue their Direct Pay.
- In the event the employee returns to pay status and has paid premiums that they may be eligible for a refund, he/she must contact the carrier to request the refund.

**IV. THE DEPARTMENT'S ROLE IN THE DIRECT PAYMENT PROCESS INCLUDES:**

- Offer Direct Pay to all employees enrolled in a health plan and on non-pay status for one or more pay periods.
- Provide the employee two copies of the completed direct pay form.
- Assist employees in adding or deleting eligible dependents.
- Enter the Direct Pay enrollment and any subsequent changes to health coverage in the my|CalPERS system and retain all supporting documentation.
- Submit premium payments to the carrier for the 120-day death benefit for Direct Pay enrollees.
- If employee declines to enroll in Direct Pay, cancel the health coverage in the my|CalPERS system.

**IMPORTANT PRIVACY INFORMATION**

Submission of the requested information is mandatory. The information requested is collected pursuant to Government Code (Section 20000. et seq.) and is used for administration of the CalPERS Board's duties under the Public Employees' Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians and insurance carriers but only in strict compliance with current statutes regarding confidentiality. Failure to supply the information may result in CalPERS being unable to perform its functions regarding your status.

You have the right to review your CalPERS membership file. For questions concerning your rights under the Information Practices Act of 1977, please contact the CalPERS Customer Contact Center at **1-888-CalPERS** (or 1-888-225-7377).

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, State, or local governmental agency requesting an individual to disclose a Social Security number to inform the individual whether the disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. Section 111 of Public Law 101-173 requires group health plans to collect and provide member Social Security numbers for the coordination of federal and State benefits. Furthermore, the CalPERS health program requires each enrollee's Social Security number for identification purposes and to verify eligibility for benefits.

The CalPERS health program uses Social Security numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification.
2. Payroll deduction and state contribution for state employees.
3. Billing of contracting agencies for employee and employer contributions.
4. Reports to the CalPERS and other state agencies.
5. Coordination of benefits among health plans.
6. Resolution of member complaints, grievances and appeals with health plans.

# Health Benefits *Continue*

### Misc Enrollment Information

**Dual CalPERS coverage** occurs when an employee is enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. **This duplication of coverage is against the law.** When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. The employee may be responsible for all costs incurred from the date the dual coverage began. Members may enroll in both a CalPERS health plan and a health plan provided through another employer. For example, a spouse may enroll in a CalPERS plan and in the plan from his or her private employer. In this case, the two plans may coordinate benefits.

When two active or retired members are married to each other or in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. **Parents cannot split enrollment of dependents.** CalPERS will retroactively cancel split enrollments. Employees may be responsible for all costs incurred from the date the split enrollment began.

### FlexElect Cash Option (Opt Out of Health and or Dental)

Refer to the Flex-Elect/CoBen Section of the Attendance Clerk Manual.

### Health & Dental Benefit Coverage into Retirement

The health benefit enrollment of an active employee will continue automatically into retirement when the employee retires within one full pay period of their permanent separation (retirement) date from employment.

Dental benefits may continue into retirement for eligible employees, however it is not automatic. Employees who are retiring and would like their dental benefits to continue into retirement they will need to complete and submit a new Dental Plan Enrollment Form STD 692 to their Personnel Specialist. The dental enrollment is then keyed into myCalPERS or faxed by the PS prior to separation and retirement.

### Retirees

Once an employee retires, CalPERS becomes their Health Benefits Officer. To make any health benefit enrollment changes they would contact CalPERS at 888-225-7377 or write to CalPERS at P.O. Box 942714, Sacramento, CA 94229-2714 for assistance.

***Refer to the Dental Section in the Attendance Clerk Manual for a sample of the Dental Plan Enrollment form STD 692.***

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# Dental Benefits

The California Department of Human Resources (CalHR), Benefits Division administers the State's Dental Insurance Program. While CalHR sets policy and procedures on enrollment and eligibility, the actual enrollment documents are reviewed for accuracy and completeness by Attendance Clerks and Personnel Specialists then processed for active employees by the State Controllers' Office (SCO).

This section contains the following topics:


| Topic | See Page |
|---|---|
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| Dental Plans | 258 |
| Enrollment | 259 |
| Permanent Intermittent (PI) Employee Enrollment | 259 |
| Dental Benefit Forms Completion (STD-692) | 260 |
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| Return to Pay Status | 280 |
| Dental Benefit Coverage into Retirement | 280 |

# Dental Benefits *Continue*

### Eligibility

Employees eligible to enroll or continue enrollment in the State's Dental Program:

- Permanent State employees with a time base of half-time or more who are designated Rank and File, Managerial, Supervisory, Confidential, Exempt, Excluded, Constitutional Officers, Employees of the Judicial Council, and all State Superior, Appellate, and Supreme Court Judges.

- An employee appointed to a Limited-Term (LT) or Temporary Authorization (TAU) with an appointment of six months or more, with a time-base of half-time or more.

- Permanent-Intermittent (PI) employees who are credited with a minimum of 480 hours worked each six-month qualifying control period, January 1 - June 30 and July 1 - December 31.
    - Hours worked during a qualifying period in a permanent, temporary authorization (TAU) or limited-term (LT) appointment may be counted toward the 480 hours if the employee subsequently receives a PI appointment with no break in service.
    - An employee who permanently separates and reinstates as a PI employee must work the 480 hours in a qualifying control period to be eligible for coverage, regardless of the length of the break in service.
    - An enrolled employee whose time base changes to PI will have coverage continued until the end of the next control period. At that time, the employee must re-qualify based on his/her PI status.
    - A PI employee who transitions into a LT position during a control period, with no break in service, may combine the hours worked as an LT with the PI hours to qualify for dental coverage at the end of that control period. The LT time base must be half-time or more.

- A former retired State employee reinstated to a permanent intermittent position. However, retirees reinstated to a permanent intermittent position must re-qualify during the next control period.

### Dental Plans

The following provides a brief description of the **three types** of dental plans available; prepaid, preferred provider option and indemnity:

- A **prepaid plan** requires that the enrollee choose a dentist from a specific list of dentists who contract with each prepaid dental company. These dentists make up what is referred to as the dental carrier's provider network. Most basic services are covered at no cost to the enrollee.
    - Safeguard (prepaid) plan offers two plans. Represented employees have the standard plan. Excluded employees and retirees have the enhanced plan.
    - The monthly premium is fully paid by the State and no premium deduction is taken from the monthly pay warrant of the employee.

# Dental Benefits *Continue*

### Dental Plans Continue

- **Delta Preferred Provider Option (PPO)**, a preferred provider option plan allows enrollees to select any licensed dentist for services. However, enrollees receive the maximum benefit available under the program when they choose one of the plan's in-network dentists. Similar to the indemnity plan, individuals who enroll in the plan are required to pay a monthly premium co-payment. Represented, excluded, and retired employees have the same coverage under the PPO plan.

- **Delta Dental Premier**, an indemnity plan does not use a provider network like the prepaid or preferred provider plans. Enrollees are allowed to select the dentist of their choice. With an indemnity plan there are set limits that the plan will pay for each specific type of dental treatment. Enrollees are responsible for paying any remaining balance that might be due based on the type of dental treatment provided. The State pays a share of the monthly premium with the balance deducted from the monthly pay warrant of the employee.

### Enrollment

Eligible employees appointed permanent, LT or TAU with a time base of half-time or more and six months or more, have 60 days from the effective date of their appointment to complete and submit a Dental Plan Authorization Form STD 692 form to Office of Human Resources (OHR). It is the department's responsibility to advise each employee of the 60 day enrollment time limitation and to ensure that employees are provided information on the dental plans available. Eligible employees, who do not wish to enroll in a dental plan within the 60 day limit, must be advised that they will not be able to enroll until the next open enrollment period. These employees must complete Section D, and sign/date the Dental Plan Authorization Form STD 692. **This document, declining coverage, should be retained in the employee's personnel file**. No further action is required by the Department. Do not submit documents declining enrollment to SCO or CalHR.

### Permanent Intermittent (PI) Employees Enrollment

PI employees who meet the eligibility criteria described above in the eligibility section may enroll in a state-sponsored dental plan. The earliest possible effective dates of enrollment are August 1st or February 1st, based upon the end of the control period, ending June 30th or December 31st. Completed STD 692 enrollment forms must be submitted to the employing office within 60 calendar days after the end of the control period.

# Dental Benefits *Continue*

**Sample of Dental Plan Enrollment Authorization - STD 692**

Instructions for completing the STD 692 can be found in the Benefits Section on CalHR's website STD 692 Dental Benefit Form Completion

Clear Print

D

STATE OF CALIFORNIA - CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

**DENTAL PLAN ENROLLMENT AUTHORIZATION**

STD. 692 (REV. 2/2016)

SAMPLE

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY - SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

**SECTION A**

1. TYPE OF ACTION

- NEW - ENROLLING IN A PLAN FOR THE FIR (Compl ections and
- CANCEL - (Complete Sections A, C, D and Pe Office co ete E Box
- CHANGE - CHANGING PLANS OR DEPENDE T CO RA (Com e Sec B, C, a D)
- COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE (Complete Sections A, B, and D)

2. NAME (First) (Middle) (Last)

ADDRESS (Number and Street)

(City, State, and Zip)

3. CHECK IF PERMANENT INTERMITTENT EMPLOYEE

4. MARITAL STATUS: MARRIED SINGLE DOMESTIC PARTNER

5. GENDER: MALE FEMALE

6. SOCIAL SECURITY NUMBER

7. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER

**SECTION B**

1. NAME OF DENTAL PLAN

PR VIDER/FA LITY NUMBER (If applicable) (prepaid plans only)

3. W EMBER ENROLLMENT, LIST ALL FAMILY MEMBERS CURRENTLY ENROLLED, AS WELL AS FAMILY MEMBERS TO BE ADDED AND/OR DELETED. ENTER THE ACTION CODE A (ADD) AND/OR D (DELETE) BESIDES THE NAMES OF ONLY THOSE MEMBERS TO BE ADDED OR DELETED.

| ACTION CODE | LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (Include self) (First) (Middle) (Last) | DATE OF BIRTH (MM/DD/YY) | FAMILY RELATIONSHIP | GENDER |
|---|---|---|---|---|
| | | | SELF | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |
| | SSN | | | |

**SECTION C** (Complete for Plan changes if different than B-1 and cancellations only)

1. PRIOR DENTAL PLAN NAME

**SECTION D**

1. CHECK APPROPRIATE BOX

- I DO NOT WISH TO ENROLL IN A DENTAL PLAN (Keep in employee's file)
- I ELECT TO ENROLL IN (OR CHANGE TO) A DENTAL PLAN AS SHOWN ABOVE AND AUTHORIZE DEDUCTIONS TO BE MADE FROM MY SALARY OR RETIREMENT ALLOWANCE TO COVER MY SHARE OF COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. I ALSO CERTIFY THAT THE NAMES OF THE PERSONS LISTED IN SECTION B, ITEM 3 ARE ELIGIBLE FAMILY MEMBERS AS DEFINED BY THE STATE OF CALIFORNIA AND ARE NOT ENROLLED IN ANOTHER STATE OF CALIFORNIA DENTAL PLAN.
- I ELECT TO CANCEL THE DENTAL PLAN SHOWN ABOVE.

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE (See Privacy Information on reverse of employee copy)

3. DATE SIGNED

**SECTION E** *(FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)*

| 1. EMPLOYER DED.CODE | 2. DENTAL ORG. CODE | 3. PARTY CODE | 4. PAY PERIOD | 5. STATE SHARE AMOUNT | 6. EMPLOYEE or COBEN DEDUCTION AMOUNT | 7. EMPLOYEE DESIGNATION | 8. BARGAINING UNIT | 9. TOTAL PREMIUM AMOUNT |
|---|---|---|---|---|---|---|---|---|
| CSU-150<br>NON-CSU-351 | | | MONTH YEAR | $ | $ | | | $ |

| COMPLETE ON CHANGES ONLY | | | 12. PERMITTING EVENT DATE (MM/DD/YY) | 13. PERMITTING EVENT CODE | 14. EFFECTIVE DATE OF ACTION | 15. AGENCY CODE | 16. UNIT CODE | 17. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED) |
|---|---|---|---|---|---|---|---|---|
| 10. PRIOR EMPLOYER DED. CODE | 11. PRIOR DENTAL ORG. CODE | PRIOR PARTY CODE | | | | | | |
| CSU-150<br>NON-CSU-351 | | | MONTH DAY YEAR | | MONTH DAY YEAR<br>1 | | | AGENCY<br>CALPERS RETIREE |

18 REMARKS

19. SIGNING PERSONNEL OFFICER'S NAME (Please Print)

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 and that I am authorized to make this certification; that the employees named herein is eligible for enrollment in the State Dental Insurance Program.*

21. TELEPHONE NUMBER (Include Area Code)

22. DATE RECEIVED IN EMPLOYING OFFICE

Month Day Year

23. EMAIL ADDRESS

Distribute one copy each to Controller, Carrier, Agency, and Employee

# Dental Benefits *Continue*

## Instruction for Completing the STD 692

**Instructions for Completion of the Dental Plan Enrollment Authorization (STD. 692)**

**SECTION A**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **1. Type of Action** | **New** | Check if employee is enrolling for the first time, re-enrolling or reinstating from retirement. | Check if employee is continuing coverage into retirement. | N/A |
| | **Cancel** | Check if employee is canceling all coverage. | Check if employee elects to cancel current dental plan. | N/A |
| | **Change** | Check if employee is currently enrolled and is changing dental plans (only when authorized), adding or deleting family members. | Check only if employee is continuing coverage into retirement and current plan is not available in service area. | N/A |
| | **COBRA** | N/A | N/A | Check this box |
| **2. Name and Address** | | Enter employee's name and address as shown on EAR document | Enter employee's name and mailing address as reported on CalPERS records. | Enter eligible person's name and address. |
| **3. PI Employee** | | Check if employee's time base is Permanent-Intermittent (PI). | N/A | N/A |
| **4. Marital Status** | **Married** | Check if employee is married. | Check if employee is married. | Check if employee is married. |
| | **Single** | Check if employee is not married or divorced. | Check if employee is not married or divorced. | Check if eligible person is a dependent continuing coverage. |
| | **Domestic Partner** | Check this box. | Check if employee has a domestic partner. | Check if employee has a domestic partner. |
| **5. Sex** | | Check appropriate box. | Check appropriate box. | Check appropriate box. |
| **6. Social Security Number** | | Enter employee's social security number. | Enter employee's social security number. | Enter social security number of eligible person enrolling (i.e. employee, dependent, spouse). |
| **7. Spouse's or Domestic Partner's Social Security Number** | | Enter spouse or domestic partner's social security number if applicable. | Enter spouse or domestic partner's social security number if applicable. | Enter spouse or domestic partner's social security number if spouse is enrolled as a dependent of employee. |

**Instructions for Completion of the Dental Plan Enrollment Authorization (STD. 692)**
**(Continued)**

**SECTION B**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **1. Name of Dental Plan** | | Enter name of dental plan employee is enrolling in. | Enter name of dental plan employee is currently enrolled in. | Enter name of dental plan eligible person is currently enrolled in. |
| **2. Provider Facility Number (if applicable)** | | Enter facility number if enrolling in a prepaid plan (i.e. DeltaCare USA, Premier Access, Safeguard, Western). | Enter facility number if enrolled in a prepaid plan (i.e. DeltaCare USA, Premier Access, Safeguard, Western.) | Enter facility number if enrolled in a prepaid plan (i.e. DeltaCare USA, Premier Access, Safeguard, Western). |
| **3. Enrollment Information** | **Action Code** | Enter "A" for new enrollments or when adding an eligible dependent. Enter "D" if dependent is being deleted. | Enter "A" for employee and each eligible dependent. | Enter "A" for enrollee and each eligible dependent. |
| | **Name DOB Relation-ship.** | Enter full name, date of birth and relationship of eligible dependent to employee. | Enter full name, date of birth and relationship of eligible dependent to employee. | Enter full name, date of birth and relationship of eligible dependent to enrollee. |
| | **Gender** | Enter appropriate initial (i.e. M or F) | Enter appropriate initial (i.e. M or F) | Enter appropriate initial (i.e. M or F) |

**SECTION C**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **1. Prior Dental Plan** | | Enter name of dental plan being cancelled or changed. | Enter name of dental plan employee is currently enrolled in, if employee elects to cancel dental coverage prior to retirement or where a change of plan is appropriate. | N/A |

# Dental Benefits *Continue*

## Instruction for Completing the STD 692 Continue

**Instructions for Completion of the Dental Plan Enrollment Authorization (STD. 692)**
**(Continued)**

**SECTION D**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **1. Election Boxes** | **First Box** | Check if eligible employee does not want dental coverage. Do not send form to SCO or CalHR. | N/A | N/A |
| | **Second Box** | Check for new enrollment or change to current dental coverage. | Check if employee is continuing coverage into retirement. | Check if employee or eligible dependents are continuing coverage under COBRA. |
| | **Third Box** | Check for an employee electing to cancel coverage or if a department is cancelling coverage as an "administrative deletion". | Check if employee elects to cancel dental coverage. | N/A |
| **2. Signature** | | Employee must sign name. | Employee signature or Agency may type in "Administrative Document". | Person enrolling must sign name. |
| **3. Date Signed** | | Administrative deletions or cancellations do not require employee signature. | | |

**SECTION E**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **1. Employer Ded. Code** | **CSU-150** | For use by CSU only. | For use by CSU only. | N/A |
| | **Non-CSU-351** | Check for all transactions, except cancellations. | N/A | N/A |
| **2. Dental Org. Code** | | Enter three digit dental plan code that corresponds with the employee's choice of dental plan. | Enter three digit dental plan code of plan employee is currently enrolled in. | Enter three digit dental plan code of plan eligible person is enrolled in. |

**Instructions for Completion of the Dental Plan Enrollment Authorization (STD. 692)**
**(Continued)**

**SECTION E (Continued)**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **3. Party Code** | | Enter "1" for employee only; "2" for employee and one dependent; "3" for employee and two or more dependents. | Enter "1" for employee only; "2" for employee and one dependent; "3" for employee and two or more dependents | Enter "1" for employee only; "2" for employee and one dependent; "3" for employee and two or more dependents. |
| **4. Pay Period*** | | Enter the month and year (Example: month =01; year =2) | N/A | |
| **5. State Share Amount** | | Enter the amount of the State's contribution. | Enter the amount of the State's contribution. | Enter the month and year enrollee lost coverage. |
| **6. Employee or CoBEN deduction amount** | | Enter amount of employee's share of the premium to be deducted from employee's pay warrant. If amount is zero (i.e., for prepaid plans), leave blank | Enter amount of employee's share of the premium to be deducted from employee's retirement warrant. If amount is zero (i.e., for prepaid plans), leave blank. | Enter total monthly premium to be paid by employee/eligible dependent(s). |
| **7. Employee Designation** | | Enter the employee's CBID as follows: E-Excluded; M-Management; S-Supervisory; C-Confidential; R-Represented. | N/A | N/A |
| **8. Bargaining Unit** | | Enter two digit number that corresponds to the CBID on the PAR document (Example: CBID is R04 - enter 04). | N/A | N/A |
| **9. Total Premium Amount** | | Enter total amount of premium (Amounts from Items E5 + E6 = E9). | Enter total amount of premium (Amounts from Items E5 + E6 = E9). | Enter total amount of premium (should be same amount as E9). |

* Premiums are always paid one month in advance, therefore the date will always be the pay period prior to the Effective Date shown in Item 14.

# Dental Benefits *Continue*

## Instruction for Completing the STD 692 Continue

**(Continued)**

**SECTION E (Continued)**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **10. Prior Employer Deduction Code** | | Complete on changes only. | N/A | N/A |
| | **CSU-150** | For use by CSU only. | N/A | N/A |
| | **Non-CSU-351** | Check for changes only. | N/A | N/A |
| **11. Prior Dental Org. Code & Party Code** | | Enter the three digit dental plan code and party code. | N/A | N/A |
| **12. Permitting Event Date** | | Enter the date of the event permitting the action. | Enter employee's retirement date. | Enter the date of the qualifying COBRA event allowing the enrollment. |
| **13. Permitting Event Code** | | Enter appropriate permitting event code. | N/A | N/A |
| **14. Effective Date of Action** | | Enter the appropriate effective date based on the action. | The effective date is determined by whether the separation date is before or after the 10th of the month. (e.g., separation date is 4/8 and retirement date is 4/10 - effective date is 5/1; separation date is 4/15 and retirement date is 4/16 - effective date is 6/1.) | The effective date is the first of the month following the loss of dental coverage (e.g., enrollee loses coverage on 3/31; coverage would be effective 4/1). |
| **15. Agency Code** | | Enter the employee's agency | N/A | N/A |

**SECTION E (Continued)**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **16. Unit Code** | | Enter employee's reporting unit number. | N/A | N/A |
| **17. Agency Name or System (if retired)** | | Enter the name of the employee's department or agency. | Enter retirement system under which the employee will be retired (e.g., CalPERS Retired, Judges Retired, Legislative Retired) | N/A |
| **18. Remarks** | | As appropriate provide additional information in order to clarify the action being taken. Indicate the control period and hours worked during the six month qualifying control period for initial or re-enrollments of Permanent-Intermittent (PI) employees. | Enter the separation and retirement date. | Enter the qualifying event allowing the COBRA enrollment (e.g. divorce, dependent turned age 26, etc.). |
| **19. Authorized Department Representative (Please Print)** | | Authorized department representative. (Please Print) | Authorized department representative. (Please Print) | Authorized department representative. (Please Print) |
| **20. Authorized Agency Signature** | | Signature of an authorized department representative. | Signature of an authorized department representative. | Signature of an authorized department representative. |
| **21. Telephone Number with Area Code** | | Enter the telephone number of the authorized department representative. Including area code. | Enter telephone number of the authorized department representative. Including area code. | Enter telephone number of the authorized department representative. Including area code. |
| **22. Date Received in Employing Office** | | Enter the date received in the employing office. | Enter date document was completed. | Enter the date document was completed. |
| **23. Email Address** | | Enter email address. | Enter email address. | Enter email address. |

**DOCUMENT DISTRIBUTION**

| Description | | Active Employees | Retiring Employees | COBRA Continuation |
|---|---|---|---|---|
| **1. Original** | White | Send to SCO. | Send to CalPERS. | Send to dental carrier. |
| **2. Second Copy** | Yellow | Send to SCO. | Send to CalPERS. | Send to dental carrier. |
| **3. Third Copy** | Pink | Retain in employee's personnel file. | Retain in employee's personnel file. | Retain in employee's personnel file. |
| **4. Fourth Copy** | Green | Forward to employee. | Forward to retiring employee. | Send to enrollee. |

# Dental Benefits *Continue*

### Continuation of Coverage for PI Employees

Eligibility for a PI employee to continue enrollment is based upon qualification at the end of the next control period. To continue enrollment, a PI employee must receive credit for 480 paid hours in the current control period or a total of 960 paid hours in two consecutive (prior and current) control periods. If the employee does not qualify, coverage must be cancelled effective August 1, or February 1, depending on the non-qualifying control period.

An eligible PI employee has 60 days after the end of the qualifying control period to complete and sign a STD. 692 and submit it to the Personnel Office. A PI employee cannot enroll during an open enrollment period unless the open enrollment period corresponds with the completion of a control period and a portion of the 60 day time limit. However, a PI employee enrolled in a dental plan may only add/delete dependents and/or change dental plans during an open enrollment period.

Retired state employees who reinstate as a PI employee and have dental coverage, may re-enroll within 60 days after appointment. They do not have to wait until the end of the qualifying control period, however, if the employee does not qualify, coverage must be cancelled effective August 1, or February 1, depending on the non-qualifying control period.

### 24 Month Plan Restriction

All eligible newly hired represented employees in Bargaining Units 1 through 21, (except Units 2, 7, 8, 16, 17, 18, 19, and excluded employees), are required to select their dental plan coverage from one of the four available state-sponsored prepaid dental plans. Newly hired employees may select only a prepaid plan until they have completed **24 months of employment** without a permanent break during the 24-month qualifying period. At the end of the 24-month period, those employees who elected a prepaid plan will have 60 days to change their enrollment to Delta Dental Premier or Delta Dental PPO. **Those employees who chose not to enroll in a prepaid dental plan may elect Delta Dental, within 60 days after completing the restriction period, unless they enrolled in the FlexElect cash option for dental coverage.**

All eligible employees who reinstate after a permanent separation and previously had 24 months of State service (no permanent break in service during the 24 months), may enroll in the Delta Premier or PPO Plan at the time of hire.

All eligible newly hired represented employees in Bargaining Units 2, 7, 8, 16, 17, 18, 19, and excluded employees (non-represented) may elect the Delta Premier or PPO Plan, at the time of hire and are not restricted to State-sponsored prepaid plans.

It is the responsibility of the Attendance Clerk to notify all impacted newly hired represented employees of this restriction. Personnel Offices should provide the 24-month restriction end date to represented employees affected by this restriction. Personnel offices should also inform employees affected by this restriction that the employee is required to initiate a STD. 692 to enroll or change their dental coverage to a Delta Dental Plan, within 60 days from the date they complete the required 24 months of State service. Use Permitting Event Code 08 on the STD. 692 to process the change. Employees who do not take action to either enroll or change dental plans within the 60 day time period, may elect to enroll/change enrollment during the next scheduled dental open enrollment period.

# Dental Benefits *Continue*

### Permitting Events

It is the responsibility of each department to inform employees of the requirements for making changes to their dental enrollment. The rules governing the changes vary in time limits, therefore, employees should be advised to report changes to their AC as soon as possible after the event occurs. This means the **event must occur first** before the employee can file a change to their dental plan.

You may see the complete list of Dental Permitting Events here.

**ATTACHMENT C**

## DENTAL PROGRAM
## PERMITTING EVENT CODES/DATES

***EFFECTIVE DATES RULES:*** ***STANDARD*** ***First day of the month after the STD. 692 is received by the employing department. Example: Received 3/5 Effective 4/1***

***MANDATORY*** ***First day of the month following the event.***

### *NEW ENROLLMENTS*

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| New employee/eligible appointment, reinstatement from retirement, transfer from State Fair districts or Legislative branches | 01 | Appointment Date | Standard | 60 days from appointment date |
| Enrollment of self, or self and dependents, after coverage as a dependent terminates for any reason (e.g., divorce, loss of spouse, etc.) **except voluntary cancellations** | 05 | Date other coverage ended | Mandatory | 60 days from event |
| Enrollment of employee who was off active pay status during entire open enrollment period (includes return from military leave) | 07 | Date of return to pay status | Standard | 60 days from return to active pay status |
| Enroll or change from prepaid to indemnity plan after completion of required prepaid restriction period (includes CAHP and CCPOA plans) | 08 | Date prepaid restriction period ends | Standard | 60 days from date prepaid restriction period ends |

### DENTAL PROGRAM
### *FAMILY MEMBER ADDITIONS*

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Add upon return to active pay status after being off during entire open enrollment period (includes return from military leave). | 15a | Date of return to pay status | Standard | 60 days from event |
| Change of custody or adding child who has become economically dependent on employee including economic dependency created through a court order. | 16 | Date of custody change or economically dependent child is acquired | Standard | 60 days from event |
| New spouse, domestic partner and/or stepchild(ren) to a one party enrollment. | 17a | Date family member acquired | Standard | 60 days from event |
| Spouse, domestic partner and/or dependents that lost coverage to a one party enrollment **(except voluntary cancellations).** | 17b | Date other coverage ended | Mandatory (*) | 60 days from event |
| Return from military leave. | 18 | Date of return | Standard | 60 days from event |
| Newborn, adopted child, or a child at each birthday through age 6 to a one party enrollment. | 19 | Date of birth, physical custody or birthday until age 6 | Standard | 60 days from event |
| New spouse, domestic partner and/or stepchild(ren) to a two or more party enrollment. | 21a | Date family member acquired | Standard | 60 days from event |
| Spouse, domestic partner and/or dependents that lost coverage to a two or more party enrollment **(except voluntary cancellations).** | 21b | Date other coverage ended | Mandatory (*) | 60 days from event |
| Newborn, adopted child, or a child at each birthday through age 6 to a two or more party enrollment. | 22a | Date of birth, physical custody or birthday until age 6 | Standard | 60 days from event |

(*) For the addition of a domestic partner or same-sex spouse being claimed as a dependent for dental benefits the party code would say "A" for a party code of 2 or "B" for a party code of 3 or more. A or B party codes are used only if the domestic partner or same-sex spouse are not being claimed as an economic dependent by the employee.

# Dental Benefits *Continue*

## Permitting Events Continue

**DENTAL PROGRAM**
***DELETION OF CHILDREN***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Change in custody. | 23a | Date custody changed | Mandatory (*) | No time limit |
| Obtains other group coverage (NOT State-sponsored plan). | 23b | Date other coverage begins | Standard | No time limit |
| Child entering military service. | 26a | Date of entry | Mandatory (*) | No time limit |
| Death of child (Mandatory Deletion) May be done administratively upon seeing a death certificate. | 26c | Date of death | Mandatory (*) | No time limit |
| Child's 26th birthday, unless disabled (Mandatory Deletion). | 26d | 26th birthday | Mandatory (*) | No time limit |
| Child enrolling as an employee in State-sponsored dental plan (Mandatory Deletion). | 26e | Day before new coverage begins | Mandatory (*) | No time limit |
| Child no longer economically dependent (Mandatory Deletion). | 26f | Date of change in dependency | Mandatory (*) | No time limit |
| Child under age 6 (may not re-enroll until open enrollment or at each birthday until age 6). | 26g | Date document signed | Standard | Up to age 6 |

(*) No time limit but document should be processed promptly. Employees will be responsible for any claims incurred on or after the effective date for retroactive mandatory deletions.

**DENTAL PROGRAM**
***DELETION OF SPOUSE***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Spouse or domestic partner obtains other group coverage (NOT State-sponsored plan). | 24a | Date other coverage begins | Standard | No time limit |
| Spouse or domestic partner moves out of household (may not re-enroll as dependent until open enrollment). | 24b | Date of move | Standard (***) | No time limit (Not COBRA eligible) |
| Divorce or termination of a domestic partnership. May be done administratively. (May include deletion of step children [divorce] or economically dependent children [Domestic Partnership] on same document). | 27a | Date of divorce | Mandatory (*) (**) | No time limit (spouse eligible for COBRA) |
| Death of Spouse or domestic partner (Mandatory Deletion) May be done administratively upon receipt of a death certificate. | 27b | Date of Death | Mandatory (*) | No time limit |
| Spouse or domestic partner entering military service. | 27c | Date of entry | Standard | No time limit |
| Spouse or domestic partner enrolling as an employee in a State-sponsored plan (Mandatory Deletion). | 27d | Day before new coverage begins | Mandatory (*) | No time limit |

(*) No time limit but document should be processed promptly. Employees will be responsible for any claims incurred on or after the effective date for retroactive mandatory deletions.
(**) Requires copy of final divorce decree, dissolution of marriage court document, or termination of domestic partnership documentation, which should be maintained in the employee's personnel folder.
(***) Not applicable in the event of a pending divorce, separation or annulment.

# Dental Benefits *Continue*

## Permitting Events Continue

**DENTAL PROGRAM**
***PERMANENT INTERMITTENT - ENROLLMENT/CANCELLATION***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| New enrollment. | 04 | June 30 or December 31 | First of the month after the STD. 692 is received by the employing department. (NOTE: Effective date can be no earlier than February 1 or August 1) | 60 days from the end of the control period |
| Employee Appointed P.I. reinstatement from retirement to active P.I. employment status. | 04a | Date of reinstatement from retirement | First of the month following reinstatement date | 60 days from reinstatement date |
| Cancellation due to loss of eligibility. | 39 | June 30 or December 31 | August 1 or February 1 | 60 days from the event (eligible for COBRA) |

**DENTAL PROGRAM**
***MISCELLANEOUS ENROLLMENT and DELETION***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Deleting all family members (no reason for request needed) on a current basis only. | 25 | Date STD. 692 signed | Standard (*) | No time limit |
| Employee and/or dependent enrolled but not eligible or dual and/or split coverage exists | 42 | Date of original enrollment or dual and/or split coverage began | Date of original enrollment or dual and/or split coverage (**) | No time limit |
| Newly hired eligible employees terminated due to layoff then re-hired within 36 months under stated policy conditions | 01a | Date of Rehire | Standard | 60 Days from rehire date |

(*) Employee may not re-enroll dependents until open enrollment period.

(**) May be done as an administrative document. The employee must be notified regarding this change and will not be allowed to enroll in a dental plan until the next scheduled open enrollment.

# Dental Benefits *Continue*

## Permitting Events Continue

**DENTAL PROGRAM**
***CHANGE OF DENTAL PLAN***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Upon return to active pay status after being off during the entire open enrollment period. | 31 | Date of return to active pay status | Standard | 60 days from event |
| Moving out of group practice plan or service cancellation. | 34 | Date of move or service change | Standard (**) | 31 days prior to move; no time limit after move |
| Moving into group practice plan service area or service added. | 35 | Date of move or service change | Standard | 31 days prior to event; 60 days after event |
| Change in bargaining unit or employee designation **and** new dental plan options available or change required. Permitted if under the first 24 months of State service or required per MOU. | 40 | Effective date of change | Standard (*) | No time limit |

(*) No time limit but document should be processed promptly. The Personnel should ensure that employee's who transfer in from another department or have a CBID change are enrolled in the correct dental plan based on their CBID, e.g., State Plan or Union Plan.

(**) Includes service cancellation or dental office(s) no longer taking new patients.

**DENTAL PROGRAM**
***OPEN ENROLLMENT PERIOD***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| New Enrollment. | 03 | First day of open enrollment period for all open enrollment transactions. | January 1st of the following year for all open enrollment transactions | Refer to specific open enrollment instructions which are provided to departments prior to the open enrollment period. |
| Addition/deletion of a dependent(s). | 15 | | | |
| Change of plan. | 28 | | | |
| Change of plan and addition/deletion of dependent(s). (*) | 29 | | | |
| Voluntary (**) | 41 | | | |

(*) Permitting Event Code 29 may be done on one document.

(**) Use this code when cancelling dental and enrolling into FlexElect or CoBen Cash. Submit dental cancellation form and FlexElect/CoBen Cash enrollment forms **stapled** together as a package to SCO.

# Dental Benefits *Continue*

**Permitting Events** Continue

DENTAL PROGRAM

***CANCELLATION OF ALL COVERAGE***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Voluntary. | 36a | Date signed | Standard (*) | No time limit |
| Employment status changes to less than one-half time. | 38 | Date status changes | 1st day of the second month following the event | No time limit (eligible for COBRA) |

(*) Employees who voluntarily cancel dental coverage may not re-enroll in a dental plan until a dental open enrollment period, unless there is a family status change. If employee is enrolling in FlexElect Dental Cash Option, the cancellation effective date **must be** the same as the FlexElect effective date.

## Voluntary Changes

Employees may elect to make any of the following changes to their enrollment:

- Adding a newly acquired spouse, certified domestic partner and/or stepchild to a one, two, or three party enrollment.
- Adding a newborn, adopted child or child at each birthday through the age of 6 to a one, two, or three party enrollment.
- Adding a spouse, certified domestic partner and/or dependents who lost coverage to a one, two or three party enrollment. **(Must provide proof of loss of coverage - keep in employee's personnel file).**
- Adding a dependent due to a change in custody and/or acquiring an economically dependent child.
- Deleting a spouse or domestic partner who ceases to live in household (not COBRA eligible).
- Deleting a dependent who obtains other group coverage (non-State sponsored).

These voluntary additions/deletions not initiated by the employee within 60 days from the permitting event date may be processed only during a subsequent open enrollment period.

# Dental Benefits *Continue*

### Mandatory Deletions

Dependents must be deleted from coverage as follows:

- Divorced spouse must be deleted from coverage even if the divorce settlement requires the employee to provide dental coverage for the spouse. The State is not required to provide coverage for an ex-spouse. However, COBRA (Consolidated Omnibus Budget Reconciliation Act) must be offered.
- Termination of a Domestic Partnership. (Employee must provide copy of notice of termination of the domestic partnership to the personnel office and COBRA must be offered to the terminated domestic partner.)
- Death of a dependent.
- Dependent child reaches age 26 and is not disabled.
- Dependent goes into military.
- Dependent no longer economically dependent/change of custody.
- Dependent enrolled but not eligible.
- Dependent dual or split covered.

Retroactive processing is limited to six months for reimbursement of dental premiums for mandatory cancellations and/or deletions to an employee's dental coverage.

### Administrative Deletions

The following deletions are processed administratively by Personnel. **The Personnel Specialist and/or the Attendance Clerk are responsible for notifying the employee of administrative deletions.**

An employee signature is not required; the Personnel Specialist will enter "Administrative Deletion" on the Employee Signature line of the STD. 692**.**

- Dependents who reach age 26 and are not disabled.
- Employees and/or dependents enrolled but not eligible or dual/split coverage exists. The employee is responsible for any costs for dental services that were performed on him/her or any ineligible dependent.
- An employee that is enrolled but not eligible and refuses to sign the STD. 692 to change dental plans due to bargaining unit change.
    - The employee must be notified regarding this change and will not be allowed to enroll in a dental plan until the next scheduled open enrollment.
- Death of a spouse, domestic partner or child upon receipt of a death certificate.

# Dental Benefits *Continue*

### Voluntary Change of Dental Plan

An employee may change enrollment from one dental plan to another **only** under the following conditions:

- During an open enrollment period;
- Due to a physical move to an area that is not serviced by the current dental carrier; (Permitting Event Code: 34)
- Due to a physical move to an area where a dental plan was not previously available to the employee; or (Permitting Event Code: 35)
- Due to service plan cut in the employee's service area and/or the employee's current dental plan does not have a dental provider within a 50 mile radius of the employee's residence.

### Cancellation of Dental Enrollment

- Employees may voluntarily cancel their dental plan enrollment at any time by completing a STD. 692 and submitting it to their Personnel Office. These employees may not re-enroll in a dental plan until the next scheduled open enrollment period.
- Enrollment for PI employees who do not qualify during a control period must be administratively cancelled. The effective date of cancellation is February 1 for the July 1 - December 31 control period, and August 1 for the January 1 - June 30 control period. These employees may continue coverage through COBRA.
- Employees/dependents who were enrolled but never eligible must be retroactively cancelled back to the effective date of their enrollment.
- Employees who lose eligibility due to a reduction in time base to less than half-time must be administratively cancelled, with the exception of those employees approved for Partial Service Retirement.

### Termination of Coverage

An employee's coverage ceases at midnight on the last day of the month following the month in which the last premium was paid.

### Disabled Dependents

An eligible dependent who is under the age of 26 years and who is enrolled as an eligible family member, may continue to be enrolled after attaining age 26 if he/she is incapable of self-support because of physical disability or mental incapacity and if he/she is dependent upon the eligible employee or annuitant for support and care. A disability certification (CalPERS HBD 34) is required to ensure disabled dependent children remain covered after the age of 26.

# Dental Benefits *Continue*

## MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT - CalPERS HBD 34 (Page 1)

**Health Account Services**
P.O. Box 942715
Sacramento, CA 94229-2715
888 CalPERS (or 888-225-7377)
TTY (877) 249-7442
Fax (800) 959-6545

**MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT**

***COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.***

SAMPLE

| MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A. MEMBER INFORMATION | DEPENDENT INFORMATION |
|---|---|
| **NAME:**_____ | **NAME:**_____ |
| **SOCIAL SECURITY NUMBER (SSN):**_____ | **SSN:**_____ |
| **ADDRESS:**_____ | **ADDRESS:**_____ |
| **TELEPHONE** ( )_____ | **DATE OF BIRTH:**_____ |

**PART B: DEPENDENT AUTHORIZATION:** *The **dependent**, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:*

I hereby authorize my attending physician_____to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

_____ _____
Signature of Dependent **OR** Date Signed

_____ _____
Person authorized to act on his/her behalf Relationship to the dependent

**PHYSICIAN PART C:** *The **physician** is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page.*
***Please DO NOT send information copied directly from the patient's medical record at this time.***

**Dear Doctor:**
The patient requests you to complete this **Medical Report** form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

| | ***Medical Report*** |
|---|---|
| 1. | I attended the patient for the current disabling medical problem or condition from _____to _____; At intervals of _____. I last examined the patient on _____. |
| 2. | Medical History (related to disability): Date of Disability Onset:_____ |
| 3. | Diagnosis (REQUIRED): _____<br>ICD-9 Disease Code, Primary (Required) : _____<br>ICD-9 Disease Code(s), Secondary : _____<br>DSM IV Code(s) (if any) : _____ |
| 4. | Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings) |
| 5. | Current Treatment(s) and /or Medication(s) (rendered to the patient for this disability):<br>☐ The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.) |

**HBD-34 Rev 6/13**

# Dental Benefits *Continue*

## MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT - CalPERS HBD 34 (Page 2)

MEMBER: _____ DEPENDENT NAME: _____
SSN: _____ SSN: _____

| | Medical Report |
|---|---|
| 6 | Functional Assessment of Activities of Daily Living (ADLS): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten [illegible] indicates the patient [illegible] disabled [illegible] ADL skill or ability. These functional disabilities limit the patient's capacity for self support.<br>**Mobility Skills**: ____walking, ____sitting, ____standing, ____lifting, ____bending<br>**Self-care skills**: ____feeding, ____bathing, ____toileting, ____dressing<br>**Sensory skills**: ____hearing, ____seeing, ____speech, ____touch<br>**Cognitive Skills**: ____judgment, ____memory, ____planning/follow through, ____thinking/processing information |
| 7. | Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting: |

SAMPLE

**PART D: Medical Certification of Disability and Incapacity of Self Support:** For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

1. Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
   ____NO, the patient does NOT have a physically of mentally disabling injury, illness or condition.
   ____YES (Please answer Question 2.)

2. In your medical or psychiatric opinion, please select **A**, **B**, or **C**:
   ____**A**. The patient's current disability DOES NOT render him or her incapable of self-support.

   ____**B**. The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by _____.
   (projected DATE—mm / yy)
   *If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur.*
   *Please DO NOT leave the DATE blank. Answers such as "indefinite" or don't know" will not suffice.*

   ____**C**. The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a _____, _____
(Type of Physician) (Specialty, if any)
licensed to practice by the State of _____.

*PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS:*

_____ _____
PHYSICIAN'S NAME AS SHOWN ON LICENSE ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN

_____ _____
LOCAL ADDRESS STATE LICENSE NUMBER

_____ (_____)_____
CITY STATE TELEPHONE NUMBER

_____ (_____)_____
DATE FAX NUMBER

**PART E: CalPERS USE ONLY:**

____Claim approved for enrollment through _____ _____
DATE (for next review) REVIEWED BY

_____ Claim rejected. _____
DATE

**HBD-34 Rev 6/13**

# Dental Benefits *Continue*

## MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT - CalPERS HBD 34 (Page 3)

### PRIVACY INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System (CalPERS) to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections (20000. et seq.) and will be used for administration of the Board's duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to supply the information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transferred to other governmental agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

SAMPLE

You have the right to review your membership files maintained by the System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942702, Sacramento, CA 94229-2702.

Section 7(b), of the Privacy Act of 1974 (Public Law 93—579) requires that any federal, state, or local governmental agency which requests an individual to disclose his Social Security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

Health Account Services of the California Public Employees' Retirement System requests each enrollee's Social Security account number on a voluntary basis. However, it should be noted that due to the use of Social Security account numbers by other agencies for identification purposes, Health Account Services may be unable to verify eligibility for benefits without the Social Security account number.

Health Account Services of the California Public Employees' Retirement System uses Social Security account numbers for the following purposes:

1. Enrollee identification for eligibility processing and eligibility verification
2. Payroll deduction and state contribution for state employees
3. Billing of contracting agencies for employee and employer contributions
4. Reports to the California Public Employees' Retirement System and other state agencies
5. Coordination of benefits among carriers
6. Resolve member appeals/complaints/grievances with health plan carriers.

# Dental Benefits *Continue*

## Economically Dependent Children

Another person's child under age 26 may be eligible for coverage if a parent-child relationship exists. Employees must complete a State of California Dental Affidavit of Eligibility (CalHR 025) annually in order to enroll economically dependent child(ren) who are not their natural, adopted, or stepchild. The Personnel Specialist can request supporting documentation to assist with the eligibility determination. The Personnel Specialist may also reject the affidavit and enrollment request based on an incomplete affidavit or information submitted by the employee for the purposes of enrolling the dependent(s) cannot be reasonably verified. Employees will be given reasonable time to correct any deficiencies in the materials required and/or requested by the personnel office to verify the parent-child relationship.

The Affidavit of Eligibility for Dependent Children (CalHR 025) is available for use from the CalHR website at www.CalHR.ca.gov in the forms section or you may contact your Personnel Specialist for a copy of the form.

# Dental Benefits *Continue*

## Sample of State of California Dental Affidavit of Eligibility - CalHR 025 (Front)

State of California
Department of Human Resources
CalHR 025 )

Department of Human Resources
1515 S Street, 500N
Sacramento, CA 95811
Phone: 916-322-0300 Fax: 916-322-3679

### Affidavit of Parent-Child Relationship

The Public Employees' Medical and Hospital Care Act (PEMHCA), allows employees and annuitants to enroll family members in the CalPERS Health Benefits Program. Pursuant to Title 2, California Code of Regulations, 599.500(o), a "parent-child relationship" (PCR) is established when you intentionally assume parental status or duties over a child who is not your adopted, step, or recognized natural child, and meet specific enrollment criteria. The Department of Human Resources Dental and Vision Programs follows this [illegible] criteria.

SAMPLE

As specified in Section 599.500(o) and outlined below, you are required to substantiate a financial responsibility upon initial enrollment and annually thereafter, up to the child reaching age 26. You must submit a separate PCR Affidavit for each PCR dependent.

**Note:** Spouses of your adopted, step, and recognized natural children do not qualify for CalHR dental and vision coverage under any circumstances.

**SECTION A: Employee/Annuitant Information**

| 1. Name *(First)* | *(M.I.)* | *(Last)* | 2. Social Security Number | 3. Date of Birth |
|---|---|---|---|---|
| | | | | |

4. Date you assumed the primary parental status or duties for the PCR dependent:

5. Relationship to the PCR dependent:

**SECTION B: PCR Dependent Information**

| 6. Name *(First)* | *(M.I.)* | *(Last)* | 7. Social Security Number | 8. Date of Birth |
|---|---|---|---|---|
| | | | | |

| 9. Address *(if different from yours): (Street)* | *(City)* | *(State)* | *(ZIP)* |
|---|---|---|---|
| | | | |

**SECTION C: Supporting Documentation Requirements**

10. As evidenced by your selection below, you are certifying you have assumed parental status or duties and will provide the required supporting documentation for your PCR dependent with this Affidavit.

| | |
|---|---|
| **For a PCR Dependent Under Age 19:**<br>• A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent.<br>• In lieu of a tax return, for a time not to exceed one tax filing year, you may submit other documents that substantiate the child's financial dependence upon you, including, but not limited to: current legal judgments/court documents showing the subscriber's legal parental status or duties/guardianship over the child; bank, credit card, tuition or insurance statements/payments; school records; bills or mail indicating common residency with the dependent (collectively referred to as "Other Suitable PCR Documentation"). | ☐ Yes<br>☐ No |
| **For a PCR Dependent From Age 19 Up to Age 26:**<br>• A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent, OR<br>• Other Suitable PCR Documentation, as mentioned above, that substantiates that the child is financially dependent upon you provided that the child:<br>◦ Either lives with you for more than 50 percent of the time, or is a full-time student, AND<br>◦ Is dependent upon you for more than 50 percent of the child's support | ☐ Yes<br>☐ No |

CalHR 025 Page of (rev 07/2016)

# Dental Benefits *Continue*

## Sample of State of California Dental Affidavit of Eligibility - CalHR 025 (Back)

### SECTION D: Signature of Employee/Annuitant

11. I recognize this affidavit is a legally binding document. I accept full responsibility to notify my employer or CalHR of any changes pertaining to this PCR. I further understand the provision of California Government Code 20085, which states in part:
    (a) It is unlawful for a person to do any of the following:
        (1) Make, or cause to be made, any knowingly false material statement or material representation, to knowingly fail to disclose a material fact, or to otherwise provide false information with the intent to use it, or allow it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by this system.
        (2) Present, or cause to be presented, any knowingly false material statement or material representation for the purpose of supporting or opposing an application for any benefit administered by this system.

SAMPLE

**I hereby certify under penalty of perjury that the information I have provided is true and correct to the best of my knowledge.** I also agree to provide all supporting documentation requested by my employer or CalHR. I understand that each PCR dependent must be certified upon initial enrollment and annually thereafter up to age 26. I also understand that certification includes submission of this Affidavit **and** the required supporting documents.

Employee/Annuitant Signature _____ Date _____

**Important!**
**Active Employees:** Return this Affidavit and the required supporting documents to your employer.
**Retirees:** Return this Affidavit and the required supporting documents to CalPERS, if not already done.

### SECTION E: For Employer Use Only

12. I hereby certify under penalty of perjury as follows: That I am a duly appointed, qualified, and acting officer of the following agency: _____

☐ I have reviewed the above affidavit and verified the identity of the employee or annuitant submitting this affidavit.

☐ I recommend enrolling/re-certifying this PCR dependent based on the information provided and attached documentation [per CCR §599.500(o)].

☐ I do not recommend enrolling/re-certifying this PCR dependent based on the information provided and/or lack of supporting documentation [per CCR §599.500(o)].

☐ Enroll ☐ Recertify ☐ Do not enroll ☐ Do not recertify

Human Resources Manager Name (Print) _____ Human Resources Manager Signature _____ Date _____

Health Benefits Officer Name (Print) _____ Health Benefits Officer Signature _____ Date _____

CalHR 025 Page of (rev 07/2016)

# Dental Benefits *Continue*

### COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees and dependents to maintain dental benefits for either 18 or 36 months after losing coverage because of certain qualifying events.

### COBRA Qualifying Events - Benefits Continued for 18 Months

- Voluntary Termination - Covered employee voluntarily terminates or separates from employment (e.g., retires or quits), and the termination/separation will cause a loss of coverage.
- Involuntary Termination - Covered employee is involuntarily terminated from employment (other than for gross misconduct), and the termination will cause a loss of coverage. If the termination is due to "gross misconduct," the State is not obligated to offer COBRA continuation coverage.
- Reduction of time base - Covered employee's work hours are reduced voluntarily or involuntarily, and the reduction of hours will cause a loss of coverage. Reduction of hours may include:
    - Full-time to part-time
    - Strikes
    - Layoffs
    - Leave of Absence
    - Military call-up (24 months of coverage)
    - Permanent Intermittent (who loses coverage based on a non-qualifying control period)

### COBRA Qualifying Events - Benefits Continued for 36 Months

- Death - Covered employee or retiree dies, and the surviving family member is not eligible for a monthly survivor allowance from CalPERS.
- Medicare coverage begins - Covered employee or retiree becomes entitled to Medicare benefits.
- Divorce or legal separation - Covered employee or retiree is divorced or legally separated
- Domestic partnership termination - Covered employee or retiree terminates a domestic partnership (registered in the State of California).
- Change in dependent status - An eligible child of a covered employee or retiree turns age 26.

# Dental Benefits *Continue*

### Direct Pay Option

An employee who wishes to continue coverage while off pay status must complete a Dental Plan Direct Payment Authorization (STD 696), and forward the form directly to the carrier with a check or money order for the full three month premium amount. The employee's enrollment may not exceed the duration of the State's contract or one year, whichever comes first. However, in the event of an approved extension to the leave of absence, the carrier will accept direct payments beyond the normal one-year period. For employees with an approved leave extension beyond one year, the employing department must notify the carrier that direct payment of premiums will be continuing beyond one-year. Also, another STD. 696 must be completed and submitted to the new carrier if there is a change in dental carriers at the end of the contract period. If an employee on direct pay has a status change, the employing office must complete a STD. 692 and submit the enrollment form to the SCO. SCO will manually update the payroll master file and upon the employee returning to work, the update will be in place.

An employee who does not elect direct payment must complete Section B of the STD. 696, to decline continued coverage. If the employee elects not to enroll, he/she will be liable for any dental expenses incurred while off pay status. A copy should be retained in the employee's personnel file. In this instance, do not send a copy of the STD. 696 to the dental carrier.

Instructions for the completion of the STD. 696 are printed on the reverse side of the form. Personnel staff should verify that all information is completed correctly. Do not forward the original document or copies of the STD. 696 to SCO or CalHR.

### Absences/Situations Where Coverage Lapses

1. Leave of absence for one or more full pay periods other than NDI, IDL, 4800 Time or Workers Compensation with supplementation.
2. Appeal of involuntary termination (COBRA provisions apply, direct payment provisions are not applicable).
3. Suspension of one or more complete pay periods.
4. Permanent-Intermittent, enrolled but off pay status (Reduction in hours -COBRA provisions apply, direct payment provisions are not applicable).
5. Application for disability retirement is pending (employee is off pay status).
6. Pending IDL determination when all sick leave and vacation credits have been exhausted (employee is off pay status).
7. Death of an employee (120-day death benefit apply, COBRA provisions are applicable after CalPERS' determination of survivor benefits).
8. Under approved SDI benefits.

### Direct Payment of Premiums

1. Dental carriers do not send a monthly bill to an employee who elects to pay premiums directly while he/she is off pay status. Therefore, it is the responsibility of each employee to ensure premium payments are paid timely. Direct pay is normally limited to 12 months. However, in the event of an approved extension to the leave of absence, the carrier will accept direct payments beyond the normal one-year period.

# Dental Benefits *Continue*

**Direct Payment of Premiums** Continue

2. Payments must be paid in advance and cover a minimum period of three months or the length of the absence whichever is less. The employee's check/money order for the first three months must be attached to the newly completed STD. 696 and *sent to the carrier*.
3. The dental carrier must receive the initial payment by the first day of the month following the first full month the employee is off pay status. Subsequent installments and/or final payment are due to the dental carrier by the first of each subsequent three-month period. STD. 696 forms received by the dental carrier without the required payment attached will be returned to the employee. Failure to pay the required payment in a timely manner will result in the employee's dental coverage being cancelled.
4. In the event an employee returns to pay status prior to the end of his/her approved leave of absence, it will be the employee's responsibility to contact his/her dental carrier to request a refund of any direct premium overpayments.

**Addition or Deletion of Family Members While on Non-Pay Status**

An employee who has a permitting event occur while on non-pay status may make changes to his/her dental enrollment as indicated below:

1. An employee is responsible for contacting his/her Personnel Office and completing a new STD. 692 reflecting the enrollment change. The Personnel Office must forward the document to SCO for processing.
2. If an employee is on direct pay and the change results in a change of premium, a new STD. 696 must also be completed.
3. If an employee deletes any dependent prior to or during the leave, the dependent may not be re-enrolled until the next open enrollment period.

**Return to Pay Status**

Upon return to pay status (if an employee is still enrolled), the State premium contributions will commence with the first pay warrant issued by SCO. The Personnel Office should check the employee's pay warrant to verify that the dental plan name is reflected. If the dental deduction is not shown, the Personnel Specialist will need to contact SCO to establish.

**Dental Coverage into Retirement**

Employees wishing to continue dental coverage into retirement must complete a Dental Plan Authorization Form (STD 692), to initiate retiree dental coverage. The STD 692 will be keyed into myCalPERS by the Personnel Specialist. It is imperative that the Personnel Specialist receive and key the completed STD 692 prior to processing the retirement.

## Questions

For active employees, questions regarding eligibility for enrollment in the State’s Dental Program should be directed to the appropriate personnel office. For retirees, eligibility questions should be directed to the California Public Employees’ Retirement System (CalPERS) 1-888-225-7377 / TTY 1-877- 249-7442.

# Dental Benefits *Continue*

## Sample of Dental Plan Direct Payment Authorization Form - STD 696 (Font)

Print Clear

STATE OF CALIFORNIA | DEPARTMENT OF PERSONNEL ADMINISTRATION

**DENTAL PLAN DIRECT PAYMENT AUTHORIZATION**

STD 696 (REV 5/2008)

**INSTRUCTIONS:** Review General Instructions on the reverse of this form. Then, complete the following parts of this form for employees enrolled in a dental plan who are going on non-pay status (i.e., the employee will **not** receive a warrant from the State Controller's Office).

1. Parts A and B and Part D, Item 16-Employees who do not wish to continue dental coverage.
2. Parts A, C and D-Employees who wish to continue dental coverage.

*PLEASE TYPE OR PRINT USING BALL POINT PEN*

**PART A EMPLOYEE INFORMATION**

SAMPLE

| | | |
|---|---|---|
| 1. SOCIAL SECURITY NUMBER (SEE REVERSE FOR DISCLOSURE STATEMENT) | 2. NAME: Last, First, Middle Initial | 3. DATE OF BIRTH |
| 4. HOME PHONE NUMBER | 5. MAILING ADDRESS (City, State, Zip Code) | |
| 6. DENTAL CARRIER | 7. CARRIER ADDRESS | ☐ Check here for 120-day Death Benefit |

**PART B COVERAGE NOT RETAINED**

8. I do not wish to continue my dental plan coverage while off pay status. I understand my coverage will terminate at the end of the first full month I am off pay status and will not resume until the beginning of the second month after I return to pay status.

Employee Signature _____ Date _____

**PART C PREMIUM PAYMENT AGREEMENT**

9. Complete the premium calculations below. Direct payment may not exceed one year for any carrier. Payment must be for a three-month period or the length of the absence, whichever is less. The initial payment is due to the carrier on the first day of the month following the first full month the employee is off pay status. Installment and/or final payment(s) (if applicable) will then be due to the carrier on the first of each succeeding three-month period.

9A. INITIAL PAYMENT (Submit directly to carrier with this form): $ _____ Due Date _____

9B. INSTALLMENT PAYMENT(S) (IF APPLICABLE): $ _____ Due Date(s) _____

9C. FINAL PAYMENT (IF APPLICABLE): $ _____ Due Date _____

10. *I agree to pay all premiums directly to the dental plan carrier listed above by the specified due date(s) to cover the cost of enrollment as it is now or as it may be in the future. I understand that failure to pay premiums will result in suspension of my coverage. I also understand that the carrier will not bill me for any premium and no employer contribution will be made during the direct payment period.*

Employee Signature _____ Date _____

**PART D AGENCY INFORMATION** (To be completed by the Personnel Office)

| | |
|---|---|
| 11. NAME OF EMPLOYING AGENCY | 12. EMPLOYEE POSITION INFORMATION: AGENCY / UNIT / DESIGNATION / BARG. UNIT |
| 13. ADDRESS OF EMPLOYING AGENCY | |
| 14. REASON FOR DIRECT PAYMENT (SEE REVERSE FOR LIST OF SITUATIONS) | |
| 15. DATES OF ABSENCE — FROM: MONTH / DAY / YEAR — TO: MONTH / DAY / YEAR | 16. PAY PERIOD OF LAST PREMIUM DEDUCTION: MONTH / YEAR |
| 17. AUTHORIZED AGENCY SIGNATURE | 18. TELEPHONE NUMBER / 19. DATE |

**1-CARRIER COPY** **2-EMPLOYEE COPY** **3-DEPARTMENT COPY**

# Dental Benefits *Continue*

## Sample of Dental Plan Direct Payment Authorization Form - STD 696 (Back)

### DISCLOSURE OF SOCIAL SECURITY NUMBERS

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any governmental agency which requests an individual to disclose his/her social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it.

The dental insurance carriers under contract with the State of California request each enrollee's social security account number on a voluntary basis. However, it should be noted that due to the use of social security account numbers by the dental carriers for identification purposes, the dental insurance carriers may be unable to verify dental plan enrollment and ensure continuation of dental coverage without disclosure of the social security number.

Each dental insurance carrier may use the social security account number for enrollee identification and for eligibility processing only.

SAMPLE

### DENTAL PLAN DIRECT PAYMENT GENERAL INSTRUCTIONS

**I. TYPES OF SITUATIONS NECESSITATING DIRECT PAYMENT BY THE EMPLOYEE TO CONTINUE COVERAGE INCLUDE THE FOLLOWING:**

1. Leave of absence other than NDI, IDL, or Workers' Compensation with Supplementation.
2. Appeal of involuntary termination. (COBRA provisions apply; direct payment provisions are not applicable.)
3. Suspension of one or more complete pay periods.
4. Permanent Intermittent, off pay status. (COBRA provisions apply; direct payment provisions are not applicable.)
5. Applied for Disability Retirement, off pay status.*
6. Awaiting IDL determination when all sick leave and vacation credits have been exhausted.*
7. For survivor of employee.
8. Under approved SDI benefits.

*** NOTE:** Employees enrolled in a dental plan who are on non-pay status while awaiting a disability determination must direct pay if they wish to have their coverage continued. At such time as the State Controller's Office (SCO) issues warrants which include dental deductions for the months when the employee has made direct payment, the employee may apply directly to the carrier for a refund.

**II. EMPLOYEES WHO DO NOT ELECT TO RETAIN DENTAL COVERAGE WHILE ON NON-PAY STATUS ARE SUBJECT TO THE FOLLOWING TERMS:**

1. Coverage will automatically resume effective the first day of the second month following the employee's return to pay status.
2. Deductibles accrued prior to the non-payment period **will not** be carried over.
3. Portions of qualifying time accrued for required waiting periods prior to the non-payment period **will not** be carried over.

**III. EMPLOYEES WHO ELECT TO RETAIN DENTAL COVERAGE WHILE ON NON-PAY STATUS ARE SUBJECT TO THE FOLLOWING TERMS:**

1. It is the employee's responsibility to provide the carrier with a copy of the completed Direct Payment Authorization Form (STD. 696) and all payments by the established due date(s). Do not send this Authorization to the SCO or to the Department of Personnel Administration.
2. If the employee wishes to add or delete a spouse or dependent(s) he/she must notify the departmental Health Benefits Officer, complete a new State Dental Plan Enrollment Authorization (STD. 692) and mail a completed copy directly to the carrier.
3. In the event the employee returns to pay status prior to completion of the period for which he/she has already made direct payment, the employee must contact the carrier directly to request a premium refund for any full, unused months of coverage.
4. Employees in Bargaining Units 5 and 6 must make all arrangements for direct payment through their exclusive representative.

**IV. THE DEPARTMENT'S ROLE IN THE DIRECT PAYMENT PROCESS INCLUDES THE FOLLOWING:**

1. Ensuring that this form is completed for all employees who are enrolled in a dental plan and on non-pay status for one or more complete pay periods.
2. Providing the employee with both the carrier and employee copies of the completed Direct Payment Authorization Form (STD. 696) and placing the departmental copy in the employee's personnel file.
3. Upon request of the employee, assisting in the addition or deletion of an eligible spouse or dependent(s) by completing a State Dental Plan Enrollment Authorization (STD. 692) and routing the original to the Controller's Office for processing.
4. Referring all Bargaining Unit 5 and 6 employees who wish to make direct payment to their exclusive representative.

**V. EXAMPLES OF DIRECT PAYMENT CALCULATIONS:**

1. An employee and spouse are enrolled in the ABC dental plan. The employee goes on a 6-month unpaid leave beginning October 1, 2008, and elects to retain dental coverage. (Assuming employee + 1 rate of $85.12.)
   INITIAL PAYMENT: **$255.36.** DUE DATE: **Nov. 1, 2008.**
   INSTALLMENT PAYMENT(S): **$-0-.** DUE DATE(S): **None.**
   FINAL PAYMENT: **$255.36.** DUE DATE: **Feb. 1, 2009.**

2. An employee, her spouse and child are enrolled in the ABC dental plan. On July 10, 2008, the employee has a baby and begins a one-year maternity leave. She elects to retain her dental coverage, goes on NDI until August 22, 2008 and then non-pay status for the duration of the leave ending July 9, 2009. (Assuming employee + 2 rate of $123.75.)
   INITIAL PAYMENT: **$371.25.** DUE DATE: **Oct. 1, 2008.**
   INSTALLMENT PAYMENT(S): **$371.25.** DUE DATE(S): **Jan. 1, 2009** and **April 1, 2009.**
   FINAL PAYMENT: **$123.75.** DUE DATE: **July 1, 2009.**

STD 696 (REV. 5/2008)

# Vision Care Program

The California Department of Human Resources (CalHR) administers the State's Vision Care Program and maintains the contract between the State and the carrier. The current carrier, Vision Service Plan (VSP), provides vision coverage plans (State of California Plan group number - Basic Plan 12020000), (State of California Plan group number - Premier Plan 30034581) (State of California Retiree Vision Plan group number 12294067 - for retirees/annuitants).

This part contains the following topics:


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# Vision Care Program *Continue*

### Eligibility

Eligibility for the Vision Care Program is the same as for the Dental Program; see the ***"Dental"*** *section* for detailed eligibility rules.

### Enrollment

Enrollment into the State's Basic Vision Plan for eligible employees and their eligible dependents is automatic. The effective date of enrollment is based on when the Personnel Specialist keys an employee's Personnel Action Request (PAR) document into the State Controller's Office (SCO) payroll system. Eligible dependents are automatically enrolled at the same time that an employee's enrollment becomes effective. (Note: STD. 700 must be completed for Permanent Intermittent employees' enrollments.)

The vision coverage will be effective the first of the following month if the employee's PAR document is keyed into the SCO system prior to the 10th of the month (see Example 1 below).

The vision coverage will be effective the first of the second month if the employee's PAR document is keyed into the SCO system after the 10th of the month (see Example 2 below).

**Example 1**: An employee is appointed on the 3rd and the PAR document is keyed prior to the 10th of the month. The coverage is effective on the first of the following month.
**Example 2**: An employee is appointed on the 3rd and the PAR document is keyed after the 10th of the month. The coverage is effective on the first day following the second month.

***Note:*** *The Dependent Eligibility Checklist CalHR781 must be completed when enrolling dependents.*

### Retiring Employees

Employees who are retiring from the state may enroll in the Retiree/Annuitant Vision Program.

The following retiring employees are eligible to enroll:

- A civil service employee of the state.
- An elected member of the Legislature.
- A legislative employee.
- A constitutional officer.
- An employee, judge, or justice of the judicial branch of state government.

To enroll into the Retirement Vision Plan, the retiring employee will need to complete the CalHR 695 and submit the form to OHR.

Instructions for vision forms and completing the CalHR 695 forms can be located on the CalHR website:

http://www.calhr.ca.gov/state-hr-professionals/Pages/benefits-administration-manual-vision-care-program.aspx

# Vision Care Program *Continue*

**Vision Plan Enrollment Authorization (STD 700)**

The Vision Plan Enrollment Authorization (STD 700) is used in certain situations to enroll eligible employees in the State Vision Program.

The following situations require completion of a Vision Plan Enrollment Authorization (STD 700) to enroll in or cancel coverage.

- An employee who is eligible, but did not enroll, prior to implementation of the automatic enrollment.
- A permanent-intermittent employee who works a minimum of 480 hours in a six-month qualifying control period (January 1-June 30 and July 1-December 31).
- A former retired State employee who is currently enrolled in State COBRA vision benefits and reinstates as a permanent intermittent.
- A permanent-intermittent employee cancellation due to loss of eligibility.
- An employee who declines or cancels coverage may do so by completing a STD. 700 form. If at a later date the employee decides to re-enroll, another STD. 700 must be completed. The vision benefit is mandatory under the Consolidated Benefits Program (CoBen), and employees in CoBen may not cancel their State-sponsored vision coverage.
- An employee and/or eligible dependent that elects to continue the vision coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA) Program.

**For permanent intermittent employees wanting to enroll into the Premier Vision Plan, the STD. 700 needs to be completed in order to process the contribution and deduction. In addition to the STD. 700, the Premier Vision Plan Enrollment Authorization (CalHR 774) must also be completed in order to enroll a member into Premier Vision.

**Premier Vision Plan**

Effective January 1, 2013, all active State employees (with the exception of rank and file BU6 employees, as their vision benefits are provided by their union trust) are eligible to enroll in the Premier Plan. Eligible State employees enrolled in this plan shall be required to pay a minimal premium and receive a higher level of benefits. When the employee enrolls in the premier, the entire family, if applicable, must also be enrolled in the premier plan. Employees may elect the Premier Vision Plan when initially enrolling into benefits for the first time or during Open Enrollment by completing a Premier Vision Plan Enrollment Authorization (CalHR 774).

**Retirees**

Currently there is not a Premier vision (enhanced) plan for retirees/annuitants. However, if a retiring employee is already enrolled in the Premier vision plan for active employees at the time of retirement, then the retiring employee may continue the Premier through COBRA only up to 18 months by completing the CalHR 774 Premier Vision Form and checking the "New COBRA Enrollment" box. Premier vision plan is not available to retirees outside of COBRA continuation. Retirees may enroll into the retiree vision plan upon the end of their Premier plan through COBRA continuation.

# Vision Care Program *Continue*

### 12 – Month Minimum Enrollment Period

Employees enrolling into the Premier Vision Plan are required to maintain their enrollment for a minimum12-month enrollment period. An employee enrolled in this program may dis-enroll during any open enrollment period, with their enrollment ending January 1 of the next calendar year (after they have completed the minimum 12-month enrollment period). Employees dis-enrolling may not re-enroll until the next open enrollment period (unless they experience a permitting event that will allow an enrollment prior to open enrollment).

*Note: The required enrollment period can extend beyond 12 months.*

*Example: New employee enrolled in the premier plan on June 1. As long as they are eligible for benefits, they will be required to maintain their enrollment into the next calendar year. The next point when they can dis-enroll will be open enrollment with an effective date of the first of the next year.*

Example: *Enrollment is June 1, 2013 with an employee having continued benefit eligibility. The next possible time to dis-enroll is during the Open enrollment (OE) of 2014. If the employee elects to dis-enroll during OE period, it will become effective January 1, 2015.*

### Vision Permitting Event Codes

For additional codes refer to CalHR website.

**VISION PROGRAM**
**PERMITTING EVENT CODES/EFFECTIVE DATES**

***EFFECTIVE DATES RULES:*** ***STANDARD*** ***First day of the month after the STD. 700 is received by the Personnel Office.***

***MANDATORY*** ***First day of the month following the event.***

***NEW ENROLLMENT/CANCELLATION***

| Permitting Event | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|
| Eligible employee prior to automatic enrollment | 01b | Appointment Date | Standard | No time limit |
| New enrollment (Permanent Intermittent Employee)* | 04 | June 30 or December 31 | Standard (Effective date can be no earlier than August 1 or February 1) | 60 days from the end of the control period |
| New enrollment of a former retired State employee who is currently enrolled in State COBRA vision benefits and reinstates as a permanent intermittent | 04a | Appointment Date | Mandatory | 60 days from event |
| Voluntary cancellation* | 36a | Dated signed | Standard | No time limit |
| Cancellation due to loss of eligibility (Permanent Intermittent Employee) | 39 | June 30 or December 31 | August 1 or February 1 | 60 days from the event (eligible for COBRA) |

*The vision benefit is mandatory under the Consolidated Benefits Program (CoBen), and employees in CoBen may not cancel their State-sponsored vision coverage.

# Vision Care Program *Continue*

## Deletion of Ineligible Dependents

Completion of a STD 700 or CalHR 774 is required for deleting ineligible dependents from an active employee's vision plan. Ensure the employee has completed the form completely, make 2 copies; one is to be given to the employee and the original and second copy of the deletion document will need to be sent to your Personnel Specialist (PS) for processing. The PS will retain a copy of the form in the employee's personnel file. Employees who have dependents should be advised that ineligible dependents are not permitted to use the State's vision plan. Employees and retirees will be held liable for payment of services that are provided to ineligible dependents.

### Instruction for Completing the STD 700

Employee completes sections A, B, C, and D
*Section A*

- **A-1:** Employee's Social Security Number
- **A-2:** Check appropriate box of marital status
- **A-3:** Check Male or Female
- **A-4:** Employee's name
- **A-5:** Employee's mailing address
- **A-6:** Employee's date of birth
- **A-7:** Check appropriate action type
- **A-8:** Enter spouse's or domestic partner's name
- **A-9:** Enter spouse's or domestic partner's social security number
- **A-10:** Enter spouse's or domestic partner's date of birth
- **A-11:** Enter family member's name
- **A-12:** Enter family member's relationship to employee
- **A-13:** Enter family member's social security number
- **A-14:** Enter family member's date of birth
  (For additional family members, enter information on sections A-15 through A-22)

*Section B*

- **B-1:** Enter name of vision plan being authorized
- **B-2:** Enter provider/facility number (if applicable)

*Section C* - For cancellations only

*Section D* - Check one box and Employee's signature/date is required

*Section E* - For OHR

The STD. 700 can be ordered through the Department of General Services (DGS), Office of State Publishing and also available as fill and print on their web site. The form is also available as fill and print on CalHR web site:

www.dgs.ca.gov/dgs/ProgramsServices/Forms/FMC/Search/pdf_fillPrint.aspx

**http://www.calhr.ca.gov**

# Vision Care Program *Continue*

## Sample of Vision Plan Enrollment Authorization STD 700

Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF PERSONNEL ADMINISTRATION

**VISION PLAN ENROLLMENT AUTHORIZATION**

STD. 700 (REV. 2/2008)

***PLEASE TYPE OR PRINT CLEARLY USING A BALLPOINT PEN***
***SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE***
***SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY***

**V**

**SAMPLE**

**SECTION A**

1. ENROLLEE'S SOCIAL SECURITY NUMBER
2. MARITAL STATUS
   ☐ MARRIED ☐ DOMESTIC PARTNER ☐ SINGLE ☐ MALE ☐ FEMALE
3. SEX
4. NAME *(First, Middle, Last)*
5. MAILING ADDRESS *(Number and Street, City, County, State, Zip)*
6. DATE OF BIRTH
7. ACTION TYPE *(Check one)*
   A. ☐ NEW - ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*
   B. ☐ COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*
   C. ☐ CANCEL – CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

| 8. SPOUSE'S OR DOMESTIC PARTNER'S NAME *(First, Middle, Last)* | 9. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER | | 10. DATE OF BIRTH |
|---|---|---|---|
| 11. FAMILY MEMBER *(First, Middle, Last)* | 12. RELATIONSHIP | 13. SOCIAL SECURITY NUMBER | 14. DATE OF BIRTH |
| 15. FAMILY MEMBER *(First, Middle, Last)* | 16. RELATIONSHIP | 17. SOCIAL SECURITY NUMBER | 18. DATE OF BIRTH |
| 19. FAMILY MEMBER *(First, Middle, Last)* | 20. RELATIONSHIP | 21. SOCIAL SECURITY NUMBER | 22. DATE OF BIRTH |

**SECTION B *(Do not complete this Section if the Cancel box in Section A is checked)***

1. NAME OF VISION PLAN BEING AUTHORIZED
2. PROVIDER/FACILITY NUMBER *(If applicable)*

**SECTION C**

1. NAME OF VISION PLAN BEING CANCELLED

**SECTION D**

1. CHECK APPROPRIATE BOX

A. ☐ I do not wish to enroll in a vision plan. *(Keep in employee's file)*

B. ☐ I elect to enroll in a vision plan as shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. **I certify that I will only obtain vision services for myself and eligible dependents as defined by the State of California. Any unauthorized use of these services by ineligible persons is a misuse of State funds.**

C. ☐ I elect to cancel the vision plan shown above.

EMPLOYEE'S SIGNATURE *(See Privacy Notice on reverse of employee copy.)* | DATE SIGNED

**SECTION E *(For agency use only)***

| 1. EMPLOYER DED. CODE | 2. VISION PLAN CODE ORG. CODE | 3. PARTY CODE | 4. EMPLOYEE OR COBRA DEDUCTION AMOUNT | 5. STATE SHARE AMOUNT | 6. EFFECTIVE DATE OF ACTION | 7. EMPLOYEE DESIGNATION | 8. BARGAINING UNIT |
|---|---|---|---|---|---|---|---|
| **475** | | **3** | $ | $ | | | |

| 9. TOTAL PREMIUM AMOUNT | 10. PERMITTING EVENT DATE | 11. PERMITTING EVENT CODE | 12. AGENCY CODE | 13. UNIT CODE | 14. AGENCY NAME |
|---|---|---|---|---|---|
| $ | | | | | |

15. REMARKS

16. ☐ CHECK HERE IF PERMANENT INTERMITTENT EMPLOYEE

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 and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Vision Insurance Program.*

18. TELEPHONE NUMBER *(Indicate if CALNET or give area code)*

19. DATE RECEIVED IN EMPLOYING OFFICE *(MO. DAY YR.)*

# Vision Care Program *Continue*

**Instruction for Completing the Premier Vision CALHR 744**

Ensure the employee has completed the form completely, make 2 copies; one is to be given to the employee and the original and second copy of the document will need to be sent to your Personnel Specialist (PS) for processing. The PS will retain a copy of the form in the employee's personnel file.

Employee completes section A, B, and C
*Complete Section A*

- Employee's name
- Security number
- Date of birth
- Mailing address
- Telephone number
- Email address

Type of Action - Check the appropriate box

*Complete Section B*

Enter dependent information including whether dependent is being added or deleted; if there are no dependents, skip Section B and go to Section C.

- Dependent's name
- Relationship to the dependent
- Dependent's social security number
- Dependent's date of birth
- If adding dependent check (A), if deleting the dependent check (D)

*Complete Section C*

Check the appropriate box to elect to enroll or to not enroll. Employee must sign and date the bottom of Section C.

*Complete Section D* - This section to be completed by OHR

The CALHR 774 will be available as fill and print on CalHR web site.
**www.calhr.ca.gov**

# Vision Care Program *Continue*

**Sample of Premier Vision Plan Enrollment Authorization - CalHR 774**

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Print Form
Reset Form

## Premier Vision Plan Enrollment

California Department of Human Resources
State of California

### A. Employee Information

Employee Name *(First, MI, Last)* | Social Security Number | Date of Birth

Mailing Address *(Number and Street)* | City | State | Zip Code

Type of Action: ☐ New Enrollment ☐ Change ☐ Cobra ☐ Cancel

E-mail Address | Telephone #

SAMPLE

### B. Enrollment Election

☐ I elect to enroll in a vision plan as shown above and authorize deduction to be made from my warrant by the State Controller (SCO) to cover my share of the cost of enrollment as it is now or may be in the future.

Furthermore, the vision plan vendor is authorized to transmit, and SCO is authorized to accept enrollment data from the vision plan vendor. SCO shall consider my appearance on enrollment data in any form from the vision plan vendor as my authorization and agreement to initiate and make continuous deductions from my warrant for payment of premiums for a minimum 12 month period. I understand that depending on the enrollment date, my enrollment period may be greater than 12 months. You are eligible for vision benefits once each calendar year. If you elect the Premier Plan, you should consider waiting to utilize your annual benefit until the Premier Plan becomes effective. Please contact VSP should you have any questions.

☐ I do not wish to enroll into the Premier Vision Plan.

I have read and understand the general terms of enrollment. (See reverse side - page 2):

Employee Signature | Date Signed

### C. Dependent Information

| Name | Relationship | SSN | Date of Birth | Add or Delete |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If more dependents, attach additional pages; only eligible, authorized dependents may use the plan.

### D. For Employing Agency Use Only

| 1. Deduction Code | 2. Party Code | 3. Premium Deduction | 4. Effective Date of Enrollment | 5. BU/CBID |
|---|---|---|---|---|
| | | | | |

| 6. Permitting Event Date | 7. Permitting Event Code | 8. Agency Name |
|---|---|---|
| | | |

| 9. Unit Code | 10. Agency Code | 11. Remarks | 12. Agency Phone Number |
|---|---|---|---|
| | | | |

11. I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment into the State Premier Vision Plan.

Name: | Signature: | Date:

CalHR 774 | Page 1 of 2 | (rev 06/2016)

# Vision Care Program *Continue*

**Sample of Retiree Vision Plan Enrollment Authorization - CalHR 695**

**Mail or Fax Completed Form to:**
VSP - Attn: Client Administrative Services, MS 315
PO Box 997100
Sacramento, CA 95899-7100
Fax: 916.463.9031

## Retiree Vision Plan Enrollment
California Department of Human Resources
State of California

Print Form | Reset Form

### A. Retiree Information

| Employee Name *(First, MI, Last)* | Social Security Number | Date of Birth |
|---|---|---|
| | | |

| Mailing Address *(Number and Street)* | City | State | Zip Code |
|---|---|---|---|
| | | | |

Type of Action: ☐ New Enrollment ☐ Change Choose Vision: ☐ Premier Plan
☐ Cobra ☐ Cancel ☐ Basic Plan

Telephone #

SAMPLE

### B. Enrollment Election

☐ I elect to enroll in a vision plan as shown above and authorize deduction to be made from my retirement warrant by my retirement system to cover my share of the cost of enrollment as it is now or may be in the future. Furthermore, the vision plan vendor is authorized to transmit and my retirement system is authorized to accept enrollment data from the vision plan vendor. My retirement system shall consider my appearance on enrollment data in any form from the vision plan vendor as my authorization and agreement to initiate and make continuing deductions from my retirement warrant for payment of premiums for a minimum twelve month period. I understand that depending on the enrollment date, my enrollment period may be greater than twelve months.

☐ I do not wish to enroll into any Retiree Vision Plan.

I have read and understand the general terms of enrollment. (See reverse side - page 2)

Retiree's Signature _____ Date Signed _____

### C. Dependent Information (if no dependents, skip Section B and go to Section C)

| Name | Relationship | SSN | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

If more dependents, attach additional pages; only eligible, authorized dependents may use the plan.

### D. For Employing Agency Use Only

| 1. Deduction Code | 2. Party Code | 3. Retiree Premium Deduction | 4. Effective Date of Enrollment | 5. BU/CBID at retirement |
|---|---|---|---|---|
| 475 | | | | |

| 6. Permitting Event Date | 7. Permitting Event Code | 8. Agency Name |
|---|---|---|
| | | |

| 9. Unit Code | 10. Agency Code | 11. Separation Date | 12. Retirement Date | 13. Agency Phone Number |
|---|---|---|---|---|
| | | | | |

11. I hereby certify under penalty of perjury as follows: I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment into the State Retiree Vision Plan.

Name: _____ Signature: _____ Date: _____

1 copy to Vendor, 1 copy to Employing Agency, 1 copy to Retiree/Annuitant

CalHR 695 Page 1 of 2 (rev 06/2016)

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# Open Enrollment

Open enrollment is a specific period of time when eligible employees can enroll in or change and/or add eligible family members who are not currently enrolled in Health, Dental, Vision, Consolidated Benefits (CoBen) Programs and FlexElect plans. Open enrollment is scheduled annually during mid-September through mid-October. Departments are notified of open enrollment procedures prior to each open enrollment period.

Separate Open Enrollment periods are offered for Annual Leave or Sick Leave/Vacation Leave programs, Long Term Disability (Excluded Employees Only) and the Group Legal Services Insurance Plan. CalHR will notify departments when these Open Enrollments are offered.

This section contains the following topics:


| Topic | See Page |
|---|---|
| CalPERS Annual Open Enrollment Circular Letter | 293 |
| Dental, CoBen & FlexElect Open Enrollment | 294 |
| CalHR Permitting Events | 294 |
| Employees Off Pay Status and Direct Pay | 294 |
| Employees on COBRA | 295 |
| Effective Dates | 295 |
| Dental Rescind | 295 |
| Cancel or Change Open Enrollment Documents | 295 |


Open Enrollment for Health (CalPERS), Dental, Vision, CoBen and FlexElect (CalHR) are conducted during the same time and are in September/October of each year, selections made during open enrollment take effect on January 1 of the following year, with deductions beginning with the December pay warrant.

**Annual Open Enrollment Circular Letter**

CalPERS annually announce open enrollment information via Circular Letters, these letters details specific information which includes: Open Enrollment Dates, Health Program Highlights, Communications Information, Health Plan Rates and Department (Employer) Responsibilities.

# Open Enrollment *Continue*

**CalHR Dental, FlexElext, CoBEN Open Enrollment**

Open enrollment periods are scheduled annually during the month of September through mid-October; the specific dates are coordinated between CalPERS and CalHR. Departments will be notified of open enrollment procedures prior to each open enrollment period. AC's will be notified through a DGS HR Memo. Eligible employees may enroll in a dental plan, change plans, and add/delete dependents; for FlexElect and CoBen, eligible employees may enroll, cancel, or change their current options. No action is necessary for currently enrolled employees who don't want to change their FlexElect Cash Option, CoBen Cash Option, and/or dental enrollment. However, Permanent Intermittent (PI) employees must re-enroll in the FlexElect/CoBen Cash Option during open enrollment if they want to remain in the program next year. Additionally, all employees who want to continue enrollment in a FlexElect Medical and/or Dependent Care Reimbursement Account must re-enroll each year during open enrollment.

**Permitting Event Codes**

The following Dental permitting event codes should be used when completing the STD. 692 during an open enrollment period:

| Code | Permitting Event |
|---|---|
| 03 | New Enrollment |
| 15 | Addition/Deletion of dependent(s) (may use one form) |
| 28 | Change of dental plan |
| 29 | Change of plan and addition/deletion of dependent(s) (may use one form) |
| 41 | Cancelling health/dental to enroll in cash in lieu of benefits. Forms to SCO must be stapled together. |
| Leave Blank | For FlexElect and CoBen documents |

**Employees Off Active Pay Status During Open Enrollment Period**

Eligible employees, who are off active pay status during the entire open enrollment period, may contact their Personnel Office during the open enrollment period to make changes in their dental enrollment or may wait and make changes within 60 days after returning to active pay status.

Employees continuing Health and/or Dental coverage through direct pay while off pay status are eligible to make the same Open Enrollment changes as employees on active pay status.

# Open Enrollment *Continue*

### Employees on COBRA

COBRA enrollees have the same rights as active employees to make allowable changes to their coverage during the annual open enrollment period. Specific instructions will be sent to all COBRA enrollees having Health coverage. They will receive an Open Enrollment package from CalPERS and Dental coverage from CalHR prior to the beginning of the open enrollment period.

### Effective Dates

All correctly completed open enrollment documents that are submitted to the SCO within the time frames detailed in the CalHR PML will be effective January 1 of the following calendar year.

### Rescind

Employees may **NOT** rescind a dental enrollment/changes submitted during open enrollment. Employees may not cancel or change a dental election after the end of the open enrollment period unless they experience a valid change in status.

### Cancel or Change Open enrollment

Employees enrolling or making changes to their dental coverage during the open enrollment period may cancel or change their election until the end of the open enrollment period. In the remarks section of the new STD 692, indicate the type of action taken and attach a copy of the original form that was previously sent during the open enrollment period. Employees may not cancel or change a dental election after the end of the open enrollment period unless they experience a valid change in status.

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# Flex-Elect/CoBen

The FlexElect Program is a voluntary tax savings program available to eligible State employees. Departments are responsible for ensuring that all employees are provided information on the FlexElect options, ensuring that interested employees are provided a FlexElect Handbook, and for assisting those who wish to enroll in FlexElect by ensuring all the appropriate forms are completed correctly and submitted timely. The following instructions provide the information required to assist departments in accomplishing that task.

FlexElect handbook is available and can be downloaded from CalHR's website at www.calhr.ca.gov

This section contains the following topics:


| Topic | See Page |
|---|---|
| Flex Cash Option | 298 |
| Dental Cash Option 3yrs Commitment | 298 |
| Election Changes/Change in Status Event | 299 |
| Permitting Events | 299 |
| Court Order Impact Flex Elect | 305 |
| Completion of Cash Option Enrollment (STD 701C) | 305 |
| Permanent-Intermittent (PI) Enrollment | 305 |
| Change in Pay Status | 307 |
| Retired While Enrolled In Flex | 308 |

| | |
|---|---|
| CoBen | 310 |
| Benefit Allowance | 310 |
| Automatic Cancellation | 311 |
| Rates | 311 |
| CoBen Cash Options | 312 |
| Election Change/Change In Status of Events | 313 |
| Dental Plan 3 year Commitment | 313 |
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| Administration Fee | 314 |
| Permanent-Intermittent (PI) Enrollment | 314 |
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| Completion of Consolidated Benefits (CoBen) STD 702 | 317 |
| Reimbursement Account Information | 319 |
| Completion of Reimbursement Account Enrollment STD 701R | 320 |
| Cobra Initial Notice | 322 |

# Flex-Elect/CoBen *Continue*

### Flex-Elect Cash Options

Employees may elect to receive cash in lieu of their own State-sponsored medical insurance and/or dental insurance plan and must certify that they have health and/or dental insurance through a spouse, domestic partner, or another source.

Cash Option payments are taxable and the amounts are listed below:

- $128 per month in lieu of medical insurance
- $12 per month in lieu of dental insurance
- $140 per month in lieu of health and dental insurance

Employees, except permanent intermittent (PI) employees, who are currently enrolled in the Cash Option, will be automatically re-enrolled into the Cash Option for the next FlexElect Plan Year. Therefore, these employees are not required to complete a Cash Option Enrollment Authorization (STD. 701C) during the annual FlexElect Open Enrollment Period unless they wish to cancel or change their Cash Option enrollment. PI employees are required to re-enroll (complete a new STD. 701C) for each year they wish to receive the Cash Option.

Employees who complete a form to enroll in FlexElect during the annual FlexElect Open Enrollment Period have until December 31 of the same year, to cancel or change their FlexElect Open Enrollment elections (for the next plan year). This rule also applies to employees who are automatically re-enrolled in the Cash Option. Accordingly, if employees wish to cancel or change their automatic Cash Option re-enrollment after the open enrollment period, they may do so no later than December 31 (prior to the new plan year).

Employees who are not enrolled in the Cash Option and wish to enroll for the next FlexElect Plan Year, must complete a STD. 701C during the current FlexElect Open Enrollment Period.

### Dental Cash Option Three-Year Commitment

Once enrolled in the Dental Cash Option, the employee is obligated to stay in the Dental Cash for **three plan years**. After completion of the three plan year commitment, employees may enroll in a State dental plan during the next open enrollment period. To ensure compliance when employees request cash option enrollment/changes during or after the open enrollment period the three-year commitment must be monitored.

- **Exception to the three-year commitment:** If employees lose their other dental coverage, they have 60 days (after the loss of coverage) to cancel the dental cash and re-enroll into a State-sponsored dental plan. If this action is not requested within the 60-day period, employees must wait until the next open enrollment period to cancel the cash and re-enroll into a dental plan.

# Flex-Elect/CoBen *Continue*

**Election Changes/Change in Status Events**

FlexElect enrollment choices are in effect for the entire plan year, January 1 through December 31. Employees may not change or cancel their FlexElect elections during the plan year except for allowable changes in the permitting events.

In general, allowable changes in permitting events are:

- Marriage, divorce, legal separation, or annulment;
- Birth or adoption of a child;
- Death of a spouse, domestic partner, or dependent;
- Loss or commencement of spouse's or domestic partner's employment or loss of spouse's or domestic partner's medical or dental coverage due to an employment status change;
- Change in employee's, spouse's, or domestic partner's work schedule (e.g., FMLA, NDI, SDI, IDL, time-base change that results in a loss or gain of eligibility and coverage, commencement or return from an unpaid leave of absence);
- Loss or commencement of dependent's eligibility for medical coverage under the employee's health insurance plan;
- Change in place of residence or worksite of the employee, spouse, domestic partner, or dependent;
- Change in dependent care provider and/or provider dependent care cost.

**Flex-Elect Permitting Events**

The Permitting Event Codes/Date Chart provides a list of permitting events, permitting event codes, and effective date information. The Permitting Event Chart reflects newly eligible enrollment information and those actions allowed as a result of a valid change in status event. Please note that employees must submit their request (to enroll, cancel, or change) to their Personnel Specialist (PS) within 60 days from the date the change in status event occurs. Requests submitted to the PS after the 60 day time frame will not be processed.

THESE PERMITTING EVENTS ONLY APPLY TO THE FLEXELECT PROGRAM. PLEASE REFER TO THE HEALTH BENEFITS AND/OR DENTAL PROCEDURE IN THIS MANUAL FOR ALLOWABLE PERMITTING EVENTS FOR THOSE BENEFITS.

# Flex-Elect/CoBen *Continue*

**Flex-Elect Permitting Events** Continue

## FLEXELECT PROGRAM
## PERMITTING EVENT CODES/DATES

**EFFECTIVE DATES:** **STANDARD** First of the following month when correctly completed enrollment form is received at SCO by the 10th AND does not have to be returned to the agency for correction.

**MANDATORY** First of the month following the event.

### *NEWLY ELIGIBLE ENROLLMENTS*
### *NOT CURRENTLY ENROLLED IN ANY FLEXELECT OPTION*

| Permitting Event<br>Newly eligible due to the following: | Action Allowed | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|---|
| -Initial appointment (includes reinstatement following a permanent break in service)<br>-Change in time base/designation from one that was not eligible to one that is or a PI who changes to a permanent position with a time base of half-time or more<br>Marriage<br>-Divorce, legal separation, or annulment<br>-Death of a spouse<br>-Return from an approved leave of absence (if employee was on an approved leave during the entire open enrollment period) or if the leave is concurrent to a valid change in status (e.g., birth of child/maternity leave) after the employee returns to work | May newly enroll | 01 | Date of event | Standard* | 60 days after date of event |
| -Loss of spouse's or domestic partner's employment | May newly enroll in reimbursement accounts. No new cash enrollment allowed | 01a | Date of event | Standard* | 60 days after date of event |
| Change in provider dependent care cost (only when provider is not a relative)<br>-Change in physical custody of child<br>-Change in dependent care provider | May newly enroll in Dependent Care Reimbursement Account | 01b | Date of event | Standard* | 60 days after date of event |
| Birth, adoption, or child placed for adoption, newly acquired dependent | May newly enroll in reimbursement account(s) | 01c | Date of event | Standard* | 60 days after date of event |
| -Commencement of medical/dental coverage provided through spouse, domestic partner, or other source (due to an employment status change) | May newly enroll in Cash Option | 01d | Date of event | Standard* | 60 days after date of event |

*The last possible effective date for enrollment as newly eligible is December 1. Correctly completed documents must be received at SCO by November 10.

# Flex-Elect/CoBen *Continue*

## Flex-Elect Permitting Events Continue

**FLEXELECT PROGRAM**
**PERMITTING EVENT CODES/DATES**

***CHANGES IN STATUS EVENTS***
***PARTICIPANTS CURRENTLY ENROLLED IN ONE OR MORE FLEXELECT OPTIONS***

| Permitting Event | Action Allowed | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|---|
| Loss or commencement of spouse's or domestic partner's employment | Cancel/change Flex elections | 05d** | Date of event | Standard | 60 days after date of event |
| Loss of medical/dental coverage provided through spouse, domestic partner, or other source (due to an employment status change) | If currently enrolled in the Cash Option, may cancel/change Cash Option elections. (New enrollments not allowed) | 05e** | Date of event | Mandatory | 60 days after date of event |
| Commencement of medical/dental coverage provided through spouse, domestic partner, or other source (due to an employment status change) | Cancel/enroll/change Cash Option elections | 05f** | Date of event | Standard | 60 days after date of event |
| Change of physical custody of child | Cancel/enroll/change Dependent Care Reimbursement account | 16a | Date of event | Standard | 60 days after date of event |
| Newly married | Cancel/enroll/change Flex elections | 17** | Date of event | Standard | 60 days after date of event |
| Birth, adoption, or child placed for adoption | Enroll/increase reimbursement account(s) | 22 | Date of event | Mandatory | 60 days after date of event |
| Child entering military service | May cancel/decrease reimbursement account(s) (New enrollments not allowed) | 26a | Date of event | Standard | 60 days after date of event |

** For employees enrolling into a State health and/or dental plan, the cancellation date for the FlexElect Cash enrollment **must** be the same as the enrollment date into health and dental benefits, using the earliest of the two dates.

# Flex-Elect/CoBen *Continue*

**Flex-Elect Permitting Events** Continue

## FLEXELECT PROGRAM
## PERMITTING EVENT CODES/DATES

### *CHANGES IN STATUS EVENTS*
### *PARTICIPANTS CURRENTLY ENROLLED IN ONE OR MORE FLEXELECT OPTIONS*
### *CONTINUED*

| Permitting Event | Action Allowed | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|---|
| Marriage of child | Cancel/decrease reimbursement account(s) (New enrollments not allowed) | 26b | Date of event | Mandatory | 60 days after date of event |
| Death of dependent (other than spouse) | Cancel/decrease reimbursement account(s) (New enrollments not allowed) | 26c | Date of event | Mandatory | 60 days after date of event |
| Child attains age 26 (Mandatory deletion from medical/dental plan - unless disabled) | Cancel/change Flex accounts(s) (New enrollments not allowed) | 26d | Date of event | Mandatory | 60 days after date of event |
| Child attains age 13 | May cancel/decrease Dependent Care Reimbursement Account (New enrollments not allowed) | 26h | Date of event | Mandatory | 60 days after date of event |
| Divorce, legal separation, or annulment | Cancel/enroll/change Flex elections, reenroll in prior medical/dental plan(s) | 27a** | Date of event | Mandatory | 60 days after date of event |
| Death of spouse or domestic partner | Cancel/enroll/change Flex accounts. | 27b | Date of event | Mandatory | 60 days after date of event |

**For employees enrolling into a State health and/or dental plan, the cancellation date for the FlexElect Cash enrollment **must** be the same as the enrollment date into health and dental benefits, using the earliest of the two dates.

# Flex-Elect/CoBen *Continue*

**Flex-Elect Permitting Events** Continue

## FLEXELECT PROGRAM
## PERMITTING EVENT CODES/DATES

### *CHANGES IN STATUS EVENTS*
### *PARTICIPANTS CURRENTLY ENROLLED IN ONE OR MORE FLEXELECT OPTIONS*
### *CONTINUED*

| Permitting Event | Action Allowed | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|---|
| Move out of group practice plan service area | May enroll in a new plan if your plan is no longer available. May change/cancel Cash. May not change reimbursement account(s) (New enrollments not allowed) | 34** | Date of move into an area not covered by the current carrier | Standard | 31 days prior to move; no limit after move |
| New health and/or dental plan(s) in area, plan(s) not previously available | If currently enrolled in a medical and/or dental plan, may change coverage. May cancel or change Cash Option. May not change reimbursement account(s) (New enrollments not allowed) | 35** | Date of event | Standard | 60 days after date of event |
| Change in employee's or spouse's work schedule (e.g., FMLA, NDI leave, IDL, time base change or reduction of hours that results in a loss or gain of eligibility and coverage, commencement or return from an unpaid leave of absence, separation, etc.) or worksite | May cancel/change Dependent Care Reimbursement Account (New enrollments not allowed) | 37*** | Date of event | Mandatory | 60 days after date of event |

** For employees enrolling into a State health and/or dental plan, the cancellation date for the FlexElect Cash enrollment **must** be the same as the enrollment date into health and dental benefits, using the earliest of the two dates.

# Flex-Elect/CoBen *Continue*

**Flex-Elect Permitting Events** Continue

## FLEXELECT PROGRAM
## PERMITTING EVENT CODES/DATES

### *CHANGES IN STATUS EVENTS*
### *PARTICIPANTS CURRENTLY ENROLLED IN ONE OR MORE FLEXELECT OPTIONS*
### *CONTINUED*

| Permitting Event | Action Allowed | Permitting Event Code | Permitting Event Date | Effective Date of Action | Time Limit to File Document |
|---|---|---|---|---|---|
| Change in dependent care provider | May cancel/enroll/change Dependent Care Reimbursement Account | 38 | Date of event | Standard | 60 days after date of event |
| Change in provider dependent care cost | May cancel/enroll/change Dependent Care Reimbursement Account (only if the provider is not a relative) | 39 | Date of event | Standard | 60 days after date of event |
| Employee change in bargaining unit or employee designation (due to transfer, promotion, etc.) that results in a loss or gain of eligibility for FlexElect | Change medical/dental plan(s) and/or change/cancel cash option elections per union requirements (New enrollments not allowed) | 40** | Date of event | Standard | Time limit does not apply |
| Change in time base and/or appointment that results in a loss of FlexElect eligibility and coverage | Must cancel Flex election(s) | 41 | Date of event | See *** below | Time limit does not apply |
| Retiree enrolls in health and/or dental plan up to 30 days prior to retirement | Cancel Flex enrollment and reenroll in a health and/or dental plan(s) | 88 | Date HBD 12 (or STD 692) is received by the agency | Mandatory | 30 days prior to retirement |

** For employees enrolling into a State health and/or dental plan, the cancellation date for the FlexElect Cash enrollment **must** be the same as the enrollment date into health and dental benefits, using the earliest of the two dates.

***Effective Date of Action: First of the second month following the date of the event.

# Flex-Elect/CoBen *Continue*

### Court Ordered Health/Dental Coverage which Impacts Flex/CoBen Cash

Occasionally an employee receiving Flex/CoBen Cash will be issued a court order regarding the provision of benefits for their dependent(s). The court order will specify that the dependent be enrolled into health/dental benefits. The employee receiving Flex/CoBen Cash must be covered elsewhere for health and/or dental benefits and the dependent(s) should be added to those benefits to comply with the court order. A court order is not always a permitting event to allow an employee to cancel the Flex/CoBen cash.

### Completion of STD 701C

Instructions to assist employees in completing Sections 1-7 are contained in the FlexElect Handbook. Review each enrollment form to ensure it has been completed correctly. The Personnel Specialist will complete the remainder of the form, Sections 8-21.

Example situations and specific instructions for completion of the document are outlined at the following website:

http://www.calhr.ca.gov/state-hr-professionals/Pages/benefits-administration-manual-flexelect.aspx

## Permanent-Intermittent (PI) Enrollment

Permanent-Intermittent (PI) employees may enroll, but have limited eligibility. The only FlexElect option available to a PI is the Cash Option. PI employees are not eligible to enroll in a Medical and/or Dependent Care Reimbursement Account.

All PIs who expect to qualify for FlexElect during the next plan year must make an election to enroll in the Cash Option during the FlexElect Open Enrollment Period by completing a Cash Option Enrollment Authorization (STD. 701C).

PI employees who enroll in FlexElect may not cancel or change their FlexElect elections, including their choice of State-sponsored health and/or dental plans, during the plan year unless they experience a valid change in status event. See Section *"Election Changes/Change in status Events"* for information regarding changes in status events.

### Cash Option - PI Employees

PI employees do not receive the Cash Option on a monthly basis. Instead, they receive the cash as a single, lump sum six-month payment in lieu of enrollment in a State-sponsored health and/or dental plan for the January through June control period of each plan year for which they are enrolled. They are not eligible to receive the cash for the July through December control period because such payment would not be made until the next plan year. Cash Option payments made in a subsequent plan year is considered a deferral of compensation and is strictly prohibited by the IRS. Cash Option payments are taxable and are available to PI employees as follows:

- $768 in lieu of health benefits
- $72 in lieu of dental benefits
- $840 in lieu of health and dental benefits

All PI Cash Option payments are subject to the annual $12.00 FlexElect administrative fee.

# Flex-Elect/CoBen *Continue*

### PI Eligibility for Cash Option

In order to participate and receive the FlexElect Cash payment, a PI employee must meet ALL of the criteria specified below:

- must have completed a STD. 701C during the open enrollment period, or as newly eligible after open enrollment, but prior to January 1 AND
- must have been eligible to be enrolled in health and/or dental insurance for the entire January through June control period (eligibility gained as of January 1 but not effective until February 1 meets this criteria) AND
- must be paid for at least 480 hours worked during the January through June control period (*see notes below regarding multiple PI positions and NDI time) AND
- have a PI appointment from January 1 through June 30 of the Plan Year for which they have enrolled (with no break in service).

*Note:* In situations where an employee maintains multiple PI appointments during the January through June control period, the department may count the hours worked from the multiple positions regardless of whether the multiple positions are within one department or multiple departments.

PI's may not use NDI or SDI time to count towards their 480 qualifying hours in a control period to qualify for the lump-sum cash payment.

### Form Submission for Cash Option - PI Employees

Employees who were eligible for health and/or dental but were not currently enrolled and were electing the Cash Option in lieu of medical and/or dental.

These employees must have completed a STD. 701C during the open enrollment period. On or after July 1st, the Personnel Specialist will verify the qualifying hours during the January-June control period. For those employees who worked the required 480 hours AND meet the other eligibility criteria, the STD. 701C should be forwarded to OHR to request the Cash Option payment.

# Flex-Elect/CoBen *Continue*

### Change In Pay Status While Enrolled In FlexElect

#### Non-Industrial Disability (NDI)

If employees go on NDI while enrolled in FlexElect, all of their FlexElect elections will remain in effect and will be reflected on their NDI paycheck (i.e. Cash Options, and/or reimbursement account deductions, etc.).

#### Industrial Disability Leave (IDL) and Temporary Disability (TD)

If employees go on IDL or TD while enrolled in FlexElect, and they elected to receive the Cash Option for health and/or dental, their cash elections will remain in effect. Employees will receive a separate check for the Cash Option, which will be issued approximately one week after their IDL or TD paycheck is issued. If they elected to enroll in one or both of the reimbursement accounts, their deductions into the account(s) will stop for as long as they are on IDL or TD. If the employees return to regular pay status within the FlexElect Plan Year, their reimbursement account deductions will resume. However, if employees go on IDL or TD with Supplementation (IDLS or TDS), their reimbursement account deductions will continue provided the amount of their supplementation income is large enough to cover the full amount of their monthly reimbursement account deduction.

#### State Disability Insurance (SDI)

For employees in certain Bargaining Units (check the MOUs): If employees go on SDI while enrolled in a reimbursement account and/or cash option, their enrollment will stop while they are on leave. If they return to pay status in the same FlexElect plan year, their enrollment will resume. If they are enrolled in the medical reimbursement account and wish to continue to submit claims for services provided during their unpaid leave of absence, they may elect to continue to make contributions through COBRA.

#### Unpaid Leave of Absence

If employees leave "pay status" while enrolled in FlexElect, their FlexElect elections will stop for as long as they continue to remain on unpaid leave. For those employees who are enrolled in the automatic Cash Option, their Cash Option election will resume when they return to pay status.

#### Military Leave

Pursuant to Government Code Section 19775.18, state employees called to active military duty for the War on Terrorism are eligible to retain their State benefits for up to 365 calendar days above the 180 calendar days provided by GC Section 19775.17. If an employee is currently receiving Flex Cash in lieu of health and/or dental benefits, he/she may continue to receive the cash for the duration of their military leave, not to exceed the time limits mentioned above. Military Leave is not a permitting event to newly enroll into the Flex Cash Program.

Employees enrolled in the medical reimbursement account may elect to continue their coverage via COBRA or their deductions will stop for the duration of their leave.

# Flex-Elect/CoBen *Continue*

**Retiring While Enrolled In FlexElect**

Retired employees are not eligible for FlexElect. There are several different situations that may apply to employees who retire while enrolled in FlexElect.

If employees retire and;

*Choose the Cash Option instead of their own medical/dental insurance plan;*
Employees have up to 30 days prior to and 60 days following, the date of their retirement to enroll in any California Public Employees' Retirement System (CalPERS) medical/State-sponsored dental insurance plan. If employees do not enroll within the specified time period, they must wait until the next health/dental open enrollment period. The enrollment at that point would be handled through CalPERS.

*Retain their State-sponsored medical insurance plan;*
No action is necessary for employees to continue their medical insurance benefit into retirement. CalPERS will automatically continue employees' medical plans in retirement.

*Retain their own State-sponsored dental insurance;*
The employee will need to complete and submit a STD. 692 to OHR to continue their dental insurance benefits into retirement.

*Use the Medical Reimbursement Account;*
Deductions into the account will automatically stop upon retirement. Employees may continue their Medical Reimbursement Account contributions under COBRA. Submit completed Reimbursement Enrollment Authorization (STD 701R) by the employee to OHR prior to the date of retirement.

*Use the Dependent Care Reimbursement Account;*
Deductions into the account will automatically stop upon retirement. Retired employees cannot continue their dependent care contributions under COBRA.

# Flex-Elect/CoBen *Continue*

## Sample of Cash Option Enrollment Authorization STD 701C

Print Form | Reset Form

STATE OF CALIFORNIA – DEPARTMENT OF HUMAN RESOURCES

**CASH OPTION ENROLLMENT AUTHORIZATION**

STD. 701C (REV.6/2015)

**C**

**FLEXELECT PROGRAM**

*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. ☐ Newly Eligible Enrollment
C. ☐ Change in Status Event
D. ☐ Cancellation

2. SOCIAL SECURITY NUMBER

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

**PLAN ELECTIONS** *Refer to the FlexElect 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. FlexElect Cash Option 354-0[illegible] | A. Health ($128) | |
| Bargaining Units 1, 3, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15, 20 and 21 | B. Dental ($12) $ | |
| | C. Total Cash Option ($140) $ | |

SAMPLE

6. ATTESTATION OF OTHER QUALIFYING GROUP HEALTH AND/OR DENTAL 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 CARRIER'S NAME

B. DENTAL INSURANCE CARRIER'S NAME

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

D. IF YOUR HEALTH AND/OR 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 FLEXELECT CASH OPTION ENROLLMENT IN LIEU OF HEALTH AND/OR DENTAL COVERAGE WILL CONTINUE FROM YEAR TO YEAR UNTIL I TAKE ACTION TO CHANGE OR CANCEL MY ENROLLMENT. 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 FLEXELECT 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 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 regulations under the IRS Code require that my benefit choices authorized by this election form are irrevocable during my entire period of enrollment unless I have a valid "Change in Status Event" as defined in these regulations or other permitting events as described in the FlexElect Handbook. I also agree to pay the administrative fee through payroll deduction on a post-tax basis.

**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.**

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 State FlexElect Program.

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

# Flex-Elect/CoBen *Continue*

### Consolidated Benefits (CoBen)

Consolidated Benefits (CoBen) is administered by the California Department of Human Resources (CalHR) Benefits Division. Departments are responsible for ensuring that all employees are provided information on the CoBen benefit.

The two types of benefits presented under the CoBen program are:

- The Consolidated Benefits (CoBen) Program Benefit Allowance is automatically established in the State Controller's Office (SCO) payroll system to offset eligible employees' health, dental, and vision total benefits cost.
- The Consolidated Benefits (CoBen) Program Cash Option is a cash payment option, in lieu of maintaining State-sponsored health or health and dental benefits, which is available to eligible State employees. Departments are responsible for assisting those employees who wish to enroll in CoBen Cash, by ensuring that all the appropriate documents are completed correctly and timely.

### Benefit Allowance

The State will establish one "combined" employer contribution amount for an employee's health, dental, and vision benefits. The employees' benefit allowance is automatically established in the SCO payroll system; therefore, no enrollment form is required. Based on the health, dental, and vision plans an eligible employee chooses, the full premium cost is deducted from the employee's benefit allowance. Eligible employees are automatically enrolled in the State's vision plan. The vision benefit is mandatory under CoBen and eligible employees may not cancel their State-sponsored vision coverage.

The amount of employees' benefit allowance will depend on the number of dependents that employees choose to cover. If employees are enrolled in both a State-sponsored health and dental plan, their health benefit enrollment party code will determine the amount of the benefit allowance they will receive.

If the total cost of the plans employees choose is less than their benefit allowance, they receive the difference as taxable cash (excess cash) in their paycheck. The excess cash amount will be subject to state, federal, and social security taxes. In order to receive excess cash, employees must be enrolled in health, dental, and vision. If employees are not enrolled in all three benefits, then they will not be eligible to receive excess cash.

If the total cost of the plans employees choose is more than their benefit allowance, they pay the difference (out-of-pocket) with pre-tax dollars automatically deducted from their paycheck. The out-of-pocket amount will not be subject to state, federal, and social security taxes.

# Flex-Elect/CoBen *Continue*

**Benefit Allowance** Continue

If employees enrolled in health and vision only, they will receive the lesser of the total premium cost or the CoBen allowance amount.

If employees elect to receive cash in lieu of their State-sponsored health plan but enroll in a State-sponsored dental plan, then the benefit allowance will be the amount of their dental and vision premium. In this situation, employees will receive cash in lieu of health, and the employees' dental and vision premium will be fully paid. The employee will not have an out-of-pocket dental and vision premium cost.

**Automatic Cancellation**

Employees benefit allowance will automatically stop at the time of retirement, separation, benefits are canceled for non-eligibility, or there is a change in their eligibility for Consolidated Benefits. At retirement, their health and dental deduction (if any) will be shown as the State share and retiree share of the applicable premiums. The Personnel Office is required to offer employees COBRA continuation if they want to continue their State-sponsored vision coverage at the time of retirement. The State will continue to fully pay the vision premium for eligible active employees.

**Represented Employee CoBen Allowance**

The CoBen allowance for represented employees is determined through collective bargaining.

New employees who have never had State health benefit eligibility may be subject to health dependent vesting. Employees in bargaining units that have contracted for health dependent vesting are provided with 50 percent of the employer dependent contribution the first 12 months, and 75 percent of the employer dependent contribution for months 13 through 24. After 24 months, these employees will receive the full employer dependent contribution applicable to their bargaining unit. Please refer to the appropriate collective bargaining agreement for specific criteria for determining if an employee is subject to health dependent vesting.

**Rates**

The CoBen allowance for Rank and File employees is determined through collective bargaining. Rates may be subject to change through the collective bargaining process and are subject to Budget approval. Any future changes will be posted to CalHR web site. CalHR will notify departments if there are subsequent changes to these rates.

# Flex-Elect/CoBen *Continue*

### CoBen Cash Options

Employees may elect to receive cash in lieu of their own State-sponsored health insurance or health and dental insurance plan. Employees may not elect to receive cash in lieu of dental coverage only. Employees must certify that they have health and/or dental coverage through a spouse, domestic partner, or another source to be eligible for cash option.

Cash Option payments are taxable and the amounts are listed below:

- $155 per month in lieu of health and dental insurance
- $130 per month in lieu of health only

Employees in CoBen are eligible for the CoBen Cash Option in lieu of health or health and dental benefits, therefore, they are not eligible for the State's FlexElect Cash Option Program. Retired employees are not eligible for CoBen Cash.

Employees may make certain changes to their health/dental insurance for purposes of enrolling in CoBen Cash. The type of change is based on the permitting event. Refer to the CoBen Program Permitting Event Codes to determine if the event is one that will allow employees to make a change and for the appropriate reason codes, etc.

### Newly Employees

To enroll in CoBen Cash as a newly eligible employee, employees must complete Std. 702 - CoBen Cash Enrollment Election and all of the appropriate forms (HBD12/12A, STD 692) which must be submitted as a package.

Employees who are not currently enrolled in the CoBen Cash Option and wish to enroll in the Cash Option for the next Plan Year, must complete a Consolidated Benefits (CoBen) Cash Enrollment Election (STD. 702) during an open enrollment period or as newly eligible. The CoBen Cash Plan Year is from January 1 through December 31.

Employees who are currently enrolled in the Cash Option will be automatically reenrolled into the Cash Option for the next plan year. It is not necessary for these employees to complete a Consolidated Benefits (CoBen) Cash Enrollment Election (STD. 702) during a CoBen Cash Open Enrollment Period, unless they wish to cancel or change their Cash Option Enrollment.

# Flex-Elect/CoBen *Continue*

### Election Change/Change In Status Events

Under the Internal Revenue Code governing the CoBen Program, employees who enroll or make changes to their Cash Option during an Open Enrollment Period may cancel or change their election through December 31. This rule also applies to employees who are automatically reenrolled in the Cash Option. Accordingly, if employees wish to cancel their automatic Cash Option reenrollment after the Open Enrollment Period has ended, they may do so, provided it is done on or before December 31 in the same year.

- Eligible employees enrolled in CoBen Cash may also enroll in the State's FlexElect Program's, Dependent Care Reimbursement Account and/or Medical Reimbursement Account.
- Permanent-Intermittent (PI) employees wishing to participate in the Cash Option, will not have their enrollment automatically continued. PI employees are required to complete a STD. 702 each year they wish to receive the Cash Option.
- If the employee is not enrolled in a State-sponsored health and/or dental plan at the time of his/her death, then the surviving spouse and dependents can't enroll in a medical or dental plan unless the California Public Employees' Retirement System (CalPERS) determines they're eligible for survivor benefits.
- Employees who are eligible to receive survivor benefits after the death of the spouse or domestic partner can continue to receive CoBen Cash.

Employees may make certain changes to their health/dental insurance for purposes of enrolling in CoBen Cash. The type of change is based on the permitting event. Refer to the CalPERS Health Benefits and the Dental Procedure Manuals to determine if the event is one that will allow employees to make a change and for the appropriate reason codes, etc.

To enroll in CoBen Cash as a newly eligible employee, employees must complete all of the appropriate forms which must be submitted as a package.

### Dental Plan Three-Year Commitment

For dental insurance, remember that the choice employees make for dental insurance is a three-year (plan year) commitment. It is very important that employees who enroll in the cash option are made aware of the **three-year dental commitment**. After completing the three-year commitment, employees may enroll in a dental plan during the open enrollment period. There is no three-year commitment for employees who are not enrolled in the Cash Option.

If employees enroll in the Cash Option for health and dental, they may not cancel their dental Cash Option for **three years** <u>unless</u> the following occurs:

- Lose their other dental coverage;
- Cancel both their health and dental CoBen Cash during an open enrollment period; or
- Due to a valid permitting event under the CoBen Program.

If one of these events occurs, then the employee may enroll in a dental plan prior to the end of the three-year commitment period.

# Flex-Elect/CoBen *Continue*

### Delta Dental Plan 24-Month Restriction

Employees in CoBen do not serve the State Dental Program's Delta Dental 24-month restriction period. Newly hired employees and those employees who transfer from a Bargaining Unit that is not eligible for CoBen to a Bargaining Unit that is eligible for CoBen, including those employees who are currently serving the 24-month restriction will be allowed to enroll or change to a Delta Dental plan.

### Administrative Fee

Those employees who enroll in the CoBen Cash Option only in lieu of enrolling in State-sponsored benefits, will not pay a monthly administrative fee. Those employees enrolled in CoBen Cash and also enrolled in a FlexElect Program Medical and/or Dependent Care Reimbursement Account will pay a $1.00 monthly administrative fee. The administrative fee will be deducted from their after tax salary each month. The administrative fee will be determined each year by the CalHR.

### Permanent-Intermittent (PI) Enrollment

Permanent-Intermittent (PI) employees may enroll, but have limited eligibility. PI employees are not eligible to enroll in a Medical and/or Dependent Care Reimbursement Account.

All PIs who expect to qualify for CoBen Cash during the next plan year must make an election to enroll in the Cash Option during the CoBen Open Enrollment Period by completing a Consolidated Benefits Cash Enrollment Election (STD. 702). .

In the event PIs who do not qualify during the open enrollment period, will have another opportunity to enroll in the CoBen Cash during the next open enrollment period.

PI employees who enroll in CoBen Cash may not cancel or change their elections, including their choice of State-sponsored health and/or dental plans, during the plan year unless they experience a valid change in status event. See Section *"Election Changes/Change in status Events"* for information regarding changes in status events.

### Cash Option - PI Employees

Cash Option payments are taxable and available to PI employees as follows:

- $930 lump-sum payment in lieu of health and dental insurance
- $780 lump-sum payment in lieu of health only

The lump-sum cash payment is for the January through June control period for the plan year in which the PI is enrolled. PI employees are not eligible to receive cash for the July through December control period because such payment would not be made until the next plan year. Such payments made in a subsequent plan year are considered a deferral of income which is strictly prohibited by IRS.

# Flex-Elect/CoBen *Continue*

**PI Eligibility for Cash Option**

In order to participate and receive the Coben Cash payment, a PI employee must meet ALL of the criteria specified below:

- must have completed a STD. 702 during the open enrollment period, or as newly eligible after open enrollment, but prior to January 1 AND
- must have been eligible to be enrolled in health and/or dental insurance for the entire January through June control period (eligibility gained as of January 1 but not effective until February 1 meets this criteria) AND
- must be paid for at least 480 hours worked during the January through June control period (*see notes below regarding multiple PI positions and NDI time) AND
- have a PI appointment from January 1 through June 30 of the Plan Year for which they have enrolled (with no break in service).

*Note:* In situations where an employee maintains multiple PI appointments during the January through June control period, the department may count the hours worked from the multiple positions regardless of whether the multiple positions are within one department or multiple departments.

PI's may not use NDI or SDI time to count towards their 480 qualifying hours in a control period to qualify for the lump-sum cash payment.

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**Form Submission for Cash Option - PI Employees**

Employees who were eligible for health and/or dental but were not currently enrolled and were electing the Cash Option in lieu of medical and/or dental.

These employees must have completed a STD. 702 during the open enrollment period. On or after July 1st, the Personnel Specialist will verify the qualifying hours during the January-June control period. For those employees who worked the required 480 hours AND meet the other eligibility criteria, the STD. 702 should be forwarded to OHR to request the Cash Option payment.

# Flex-Elect/CoBen *Continue*

### Change In Pay Status While Enrolled In CoBen Cash

### Non-Industrial Disability (NDI) and Temporary Disability (TD)

If employees go on IDL or TD and they elected to receive the CoBen Cash Option for health or health and dental, their cash elections will remain in effect. Employees will receive a separate check for the Cash Option, which will be issued approximately one week after their IDL or TD paycheck is issued.

### Industrial Disability Leave (IDL)

If employees go on IDL while enrolled in CoBen Cash, and they elected to receive CoBen Cash for health or health and dental, their cash election will remain in effect. Employees will receive a separate check for the Cash Option, which will be issued approximately one week after their IDL paycheck is issued.

### State Disability Insurance (SDI)

For employees in Bargaining Unit 17 (only): If a Unit 17 employee goes on SDI while enrolled in the CoBen cash option, their enrollment will stop while they are on leave. If they return to pay status in the same CoBen plan year, their enrollment will resume.

### Unpaid Leave of Absence

If employees leave “pay status” while enrolled in CoBen Cash, their CoBen Cash election will stop for as long as they continue to remain on unpaid leave. If they return to pay status in the same plan year, then their enrollment will resume.

### Military Leave

Pursuant to Government Code Section 19755.18, state employees called to active military duty for the War on Terrorism are eligible to retain their State benefits for up to 365 calendar days above the 180 calendar days provided by GC Section 19755.17. If an employee is currently receiving CoBen Cash in lieu of health and/or dental benefits, he/she may continue to receive the cash for the duration of their military leave, not to exceed the time limits mentioned above. Military Leave is not a permitting event to newly enroll into the CoBen Cash Program. Employees enrolled in the medical reimbursement account may elect to continue their coverage via COBRA or their deduction will stop for the duration of their leave.

# Flex-Elect/CoBen *Continue*

### Retiring While Enrolled In CoBen Cash

Retired employees are not eligible for CoBen Cash. There are several different situations that may apply to employees who retire while enrolled in CoBen Cash.

If employees retire and;

*Choose the Cash Option instead of their own medical/dental insurance plan;*
Employees have up to 30 days prior to and 60 days following, the date of their retirement to enroll in any California Public Employees' Retirement System (CalPERS) medical/State-sponsored dental insurance plan. If employees do not enroll within the specified time period, they must wait until the next health/dental open enrollment period. The enrollment at that point would be handled through CalPERS.

*Retain their State-sponsored medical insurance plan;*
No action is necessary for employees to continue their medical insurance benefit into retirement. CalPERS will automatically continue employees' medical plans in retirement.

*Retain their own State-sponsored dental insurance;*
The employee will need to complete and submit a STD. 692 to OHR to continue their dental insurance benefits into retirement.

### Completion of STD 702

Instructions to assist employees in completing Sections 1-7 are contained on the CalHR website below. Review each enrollment form to ensure it has been completed correctly. The Personnel Specialist will complete the remainder of the form, Sections 8-21.

Example situations and specific instructions for completion of the document are outlined at the following website:

http://www.calhr.ca.gov/state-hr-professionals/Pages/benefits-administration-manual-consolidated-benefits.aspx

# Flex-Elect/CoBen *Continue*

## Sample of Consolidated Benefits (CoBen) STD 702

Print Form | Reset Form

STATE OF CALIFORNIA – DEPARTMENT HUMAN RESOURCES

**CONSOLIDATED BENEFITS (COBEN)**
**CASH ENROLLMENT ELECTION**

STD. 702 (REV. 6/2015)

**COBEN**

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

SEE PRIVACY NOTICE ON REVERSE

SAMPLE

1. ENROLLMENT *(Check appropriate box)*
A. Open Enrollment
B. Newly Eligible Enrollment
C. Change in Status Event
D. Cancellation

2. SOCIAL SECURITY NUMBER

3. NAME (First, Middle, 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**<br>**Bargaining Units 2, 7, 8, 16, 17, 18, 19, and Excluded Employees** | A. **Health Only ($130)** $<br>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. 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

# Flex-Elect/CoBen *Continue*

**Reimbursement Account Information and Procedures**

This program lets State employees set aside money in a reimbursement account to pay for certain kinds of expenses. Employees can increase their take home pay and decrease their taxable income. They will need to specify the amount to be deducted from their paycheck, and the deductions occur before tax withholding, reducing tax liability. There are two types of accounts.

- Medical reimbursement accounts (MRA) - Set aside money to reimburse eligible medical expenses.
- Dependent care reimbursement accounts - Set aside money to reimburse dependent day care expenses.

When the employee enrolls in a reimbursement account they will designate an amount to be deducted each month from their wages. That money is automatically deposited in an account for one plan year. After they receive health-related or dependent care services during that year, they will submit a claim for reimbursement from the account. A reimbursement check will be mailed to the employee.

**Enrollment**

Employees may enroll in a reimbursement account within 60 days after becoming "newly eligible" for these benefits or during the annual Open Enrollment period.

**Who Can Enroll**

An employee is eligible to enroll in a reimbursement account if they have a permanent position that is half- time or more. If the employee is in a limited term (LT) or temporary (TAU) position, they are eligible if they have a mandatory right of return to a permanent position that is half-time or more unless they are in the CoBen Program. CoBen employees are eligible even if they are in a LT or TAU appointment. If the employee is a permanent-intermittent employee, they are not eligible to enroll in a reimbursement account.

**Open Enrollment**
Open Enrollment period for FlexElect Medical Reimbursement Accounts and Dependent Care Reimbursement Accounts is usually in September through October. The specific open enrollment period dates will be communicated to departments prior to the beginning of the open enrollment period. Employees must sign and submit their documents to their Personnel Specialist no later than the last day of the open enrollment period. The effective date of any action during open enrollment is January 1 of the following year.

.

- If an employee is currently enrolled in a FlexElect Reimbursement Account and want to participate again next year, they must re-enroll.
- If an employee is enrolled or re-enroll into a FlexElect Reimbursement Account during open enrollment, they have until December 31 to cancel or change their election.

.

# Flex-Elect/CoBen *Continue*

**Reimbursement Account Information and Procedures Continue**

**Newly Eligible**

In addition to the annual open enrollment period, employees also have the opportunity to enroll in a reimbursement account within 60 days after becoming "newly eligible." Newly employees are eligible if:

- They are a new State employee hired after the open enrollment period;
- they were on an approved leave of absence during the entire open enrollment period;
- they experience a change in status that permits them to enroll as newly eligible. If they change in status results in a concurrent approved leave of absence (e.g., birth of child followed by a maternity leave), they may enroll by the deadlines specified below after they return to work; or
- their time base/employee designation changes from one that was ineligible to one that is eligible, or they change from a permanent-intermittent position to a permanent position with a time base of half-time or more.

If employees are newly eligible and want to enroll in a reimbursement account, they must submit enrollment forms to the HR Office within 60 days after becoming newly eligible. If they complete the forms correctly, and the State Controller's Office receives them by the 10th of the month, the enrollment is effective the 1st of the following month (except when the 10th is on a weekend or holiday, in which case the cut-off date will be on the next regular workday).

**Instruction of Completion 701R**

Instructions to assist employees in completing Sections 1-7 are contained in the FlexElect Handbook. Review each enrollment form to ensure it has been completed correctly. Submit to your Personnel Specialist and they will complete the remainder of the form, Sections 8-21.

Specific instructions for completion of the form are outlined in the link below:

http://www.calhr.ca.gov/state-hr-professionals/Pages/benefits-administration-manual-flexelect.aspx

**Additional Information Medical/Dependent Care**

Additional information for reimbursement accounts for Medical/Dependent Care can be found at the following links:

http://www.calhr.ca.gov/employees/Pages/reimbursement-accounts-medical.aspx

http://www.calhr.ca.gov/employees/Pages/reimbursement-accounts-dependent-care.aspx

# Flex-Elect/CoBen *Continue*

## Sample of Reimbursement Account Enrollment Authorization Form STD 701R

Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF HUMAN RESOURCES

**REIMBURSEMENT ACCOUNT ENROLLMENT AUTHORIZATION**

STD. 701R (REV. 10/2014)

**FLEXELECT PROGRAM**

**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 NOTICE ON REVERSE**

1. ENROLLMENT *(Check appropriate box)*

A. ☐ Open Enrollment
B. ☐ Newly Eligible Enrollment
C. ☐ Change Due to Permitting Event
D. ☐ Cancellation
E. ☐ COBRA Continuation

2. SOCIAL SECURITY NUMBER

3. NAME *(first, initial, last)*

**SAMPLE**

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 DED/ORG CODE | 5. TOTAL MONTHLY AMOUNT TO BE DEDUCTED | 6. For SCO Use Only Type of Change |
|---|---|---|---|
| **Medical Reimbursement Account (MRA)** | 352 - | A. $ | |
| **Dependent Care Reimbursement Account (DCRA)** | 353 - | B. $ | |

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.**

EMPLOYEE SIGNATURE

DATE SIGNED

**AGENCY USE ONLY**

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

9. EMPLOYEE CBID

10. PERMITTING EVENT DATE MO DAY YEAR

11. PERMITTING EVENT CODE

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

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

14. AGENCY CODE

15. UNIT CODE

16. REMARKS

17. AGENCY NAME

18. 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 FlexElect Program.

20. DATE RECEIVED IN EMPLOYING OFFICE (mo day year)

21. TELEPHONE NUMBER (Indicate if CALNET or give area code)

# Flex-Elect/CoBen *Continue*

**Reimbursement Account Information and Procedures** Continue

**COBRA Initial Notice**

The COBRA Initial Notice is the first of the two required COBRA notices. In compliance with the provisions of COBRA requiring the employer to notify the employees of their COBRA rights, the Personnel Specialist must provide the initial notice to employees within 90 days of their enrollment in the MRA (i.e., when they first become covered under the MRA). An exception to the 90-day rule is when a qualifying event occurs before the initial notice is provided. In that case, an initial notice must be provided along with the election notice and election form.

The COBRA Initial Notice is intended to provide a summary of their right to continue the MRA under COBRA if they experience a COBRA qualifying event.

**COBRA Election Notice and COBRA Election Form (CalHR 689)**

**Employee Responsibility** – It is the employee's responsibility to inform his/or her office when a qualifying event occurs. The Personnel Specialist must receive the notification within 60 days after the date of the event or the date on which coverage is lost. If the notice to the Personnel Specialist is not received timely, then COBRA continuation coverage will not be offered.

**Attendance Clerk –** notify the Personnel Specialist of when an employee dies, terminated from employment, or a reduction in hours that results in a loss of eligibility. At the time the qualifying event has occurred or when notified timely of a qualifying event, the Personnel Specialist must provide within 14 days, COBRA Election Notice and COBRA Election Form (CalHR 689) to the employee.

A Reimbursement Account Enrollment Authorization (STD. 701R) should also be included with the notification.

**Employee Responsibility After Receiving COBRA Election Notice and COBRA Election Form**

If the employee wishes to elect COBRA, he/she must complete the COBRA Election Form and a STD. 701R for "COBRA Continuation" and the documents to the Personnel Specialist within 60 days from the date of the COBRA Election Notice.

The Personnel Office will keep one copy of the completed STD. 701R with the COBRA Election Form in the employee's personnel file and mail the original and 1st initial payment to CalHR.

In addition, the enrollee must submit a personal check, money order, or cashier's check payable to CalHR in the amount of one monthly premium plus an additional 2% for administrative costs.

For example, if a participant elects to continue a MRA at $100.00 a month, the total monthly COBRA premium will be $102.00. Subsequently, by the first of each month the employees are responsible for submitting their COBRA payment to CalHR.

# Flex-Elect/CoBen *Continue*

**Reimbursement Account Information and Procedures** Continue

**CalHR's Responsibility After Receiving Completed COBRA Election Form**

CalHR will send a COBRA Enrollment Confirmation Memo to participants. CalHR will process the participants payments and ensure the amounts are credited to their MRA.

Events Resulting in the Loss of COBRA Coverage

1. Failure to pay the required contributions within the prescribed timeframes.
2. Failure to request reimbursement for valid medical expenses by June 30 for the prior plan year account.

Payments must be submitted and be received by CalHR the first of each month. Mail payments to:

**California Department of Human Resources**
**Benefits Division/FlexElect Program**
1515 S Street North Building, Suite 400
Sacramento, CA 95811-7258

The COBRA Election Notice and Election Form is also available on CalHR's web site.
www.calhr.ca.gov

# Flex-Elect/CoBen *Continue*

## Sample of COBRA Election form CalHR 689

CALHR
CALIFORNIA DEPARTMENT OF HUMAN RESOURCES

Print Form | Reset Form

**FlexElect Program**
**COBRA Continuation Election Form**
California Department of Human Resources
State of California

**1. Enrollee Information**

Enrollee Name

Enrollee Social Security Number

Enrollee Mailing Address (Street)

Enrollee Mailing Address (City, State, ZIP Code)

SAMPLE

Enrollee Daytime Phone Number

Date Mailed or Given to Enrollee

**2. Election to Enroll in COBRA Continuation Coverage for Medical Reimbursement Account**

☐ I elect to enroll in Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage to continue my coverage for my Medical Reimbursement Account. (Please check the box on the left.)

Signature of Enrollee

Date Signed

**3. Deadline to Return this Form**

Day 60 After the Event

The election form must be completed and returned to the address shown below by this date. If mailed, it must be postmarked by this date.

**4. Required Forms and Payment**

You must complete and include:

- This form
- The enclosed Reimbursement Account Enrollment Authorization (STD. 701 R)
- Your initial COBRA payment
- The monthly 2% administrative fee

**5. Submit Items To**

Agency Name

Agency Mailing Address (Street, City, State, ZIP Code)

Your Personnel Office will forward the completed STD. 701R form and your COBRA payment to CalHR for processing. CalHR will send you a COBRA Enrollment Confirmation Letter with instructions for future contributions into your account.

# Separation Process

This Manual Section

- Identifies the types of separations
- Defines the Labor Code Assembly Bill (AB) 2410
- Describes the responsibilities of separating employees
- Describes the Attendance Coordinator's responsibilities in processing employee's separation from State service

This section contains the following topics:


| Topic | See Page |
|---|---|
| Types of Separation | 326 |
| Assembly Bill (AB 2410) | 327 |
| Attendance Coordinator Responsibility | 328 |
| Separation Packet | 329 |
| Separation Checklist | 330 |
| ABMS Separation Alert | 332 |
| Completing PAL Entry | 333 |
| Absence and Additional Time Work STD 634 | 336 |
| Employee Separation Clearance Checklist | 339 |
| Separation/Disposition of CalPERS STD 687 | 341 |
| Part Time – Seasonal Temporary PST Retirement Plan | 349 |
| Statement of Economic Interest Form 700 | 349 |
| Service Retirement | 351 |
| Employee Death | 354 |
| Absence Without Leave (AWOL) | 355 |
| Termination of Temporary Authorization Appointment (TAU) | 357 |
| Termination of Limited Term Appointment (LT) | 358 |
| Termination of Intermittent Appointment | 359 |
| COBRA | 360 |


The Separations chapter explains the separation process and your responsibilities. A brief overview and guidelines for processing separation documents are included in this chapter.

# Separation Process *Continue*

## Types of Separations

The table below identifies the different types of separation and a brief description of each type of separation.

| Type of Separation | Description |
|---|---|
| Resignation | Voluntary resignation from any appointment including while on a leave of absence |
| Termination Without Fault | Layoff situations or for medical reasons |
| Termination with Fault | No layoff situations |
| Leave of Absence | NDI, SDI, Military Leave, Temporary |
| Retirement | Service or Disability |
| Other | Termination due to Illegal Appointment, Adverse Suspension, Rejection During Probation, Death, Cancellation of Appointment |

There are two distinct types of separations. The distinction is needed for the accumulation and computation of qualifying service toward employee benefits, rights and privileges.

## Permanent Separation

Permanent separation includes service retirement, dismissal, resignation, absence without leave (AWOL), rejection during probation, failure to meet conditions of employment and termination of limited term (LT), temporary authorization (TAU), emergency Career Executive Assignment (CEA) or exempt appointments.

## Temporary Separation

Temporary separations must be documented and includes leave of absence, military leave, suspension, disability retirement and termination for medical, layoff and displacement.

# Separation Process *Continue*

**Types of Separations** Continue

**Transfers**

Transfers are also considered a type of separation although it is not a permanent or temporary separation from State service. It is a separation from one area of State service to another.

The employee may not have physically stopped working, but the reporting unit and/or State department changes. The following examples define transfers within DGS, and to another State department:

- Transfer within the Department is when an appointment changes the employee's classification and/or reporting unit.
- Transfer out of the Department is when the employee accepts another position with another State department.

**Labor Code AB2410**

The employer (DGS) has 72 hours in which to provide payment in full, to the employee. The 72 hours is a continuous period that includes weekends and holidays. See labor code applicable to State employees via link below:

Labor Code AB2410

For example, if an employee resigns without prior notice on a Friday at 5 p.m., the employer has until 5 p.m. the following Monday to deliver wages due. If that timeframe is not met, the employer is subject to pay penalties to the employee.

***Important!*** **In order to avoid paying penalties, it is imperative the Attendance Clerk notifies the Personnel Specialist immediately of the employee's separation date and last day he/she will physically work. The Personnel Specialist will determine if a salary advance will need to be issued.**

# Separation Process *Continue*

### Attendance Coordinator Responsibility

The Separation Process is the method used when an employee separates from State service.

In the event of an employee's death, refer to Deceased Employee Guidelines.

Once you know the employee's proposed separation date, your responsibilities will be to coordinate the separation documents the employee is required to complete.

You will forward the Separation Package within each document time frame to your Personnel Specialist (PS) in the Personnel Transactions Unit (PTU) in the Office of Human Resources (OHR). Refer to Separation Documents Samples and Guidelines for instructions on completing each required form.

| | |
|---|---|
| **Attendance Coordinator's Separation Responsibilities:** | ✓ Notify the PS immediately with proposed separation date.<br>✓ ABMS Separation Alert<br>✓ Complete a Separation Document Checklist (GS-71).<br>✓ Provide employee with the separation documents and have her/him complete the documents in ink.<br>✓ Review Project Accounting Leave (PAL) or Timesheet (STD 634) for accuracy of time employee worked.<br>✓ Review all documents for thoroughness, accuracy and clarity.<br>✓ Provide employee with copies of the separation documents.<br>✓ Submit the Separation Package to PTU within 5 working days of separation. |

A delay in submission may delay the employee's final pay warrant and continuation of benefits.

# Separation Process *Continue*

### Separation Package

The table below lists the documents in the Separation Package. Refer to Separation Document Samples and Guidelines for instructions to complete each document. Unless otherwise noted, the documents are to be received in PTU within 5 working days from date of separation.

YES: Required NO: Not required OPTIONAL: Conditional ASTERISK(*): See comments

| Separation Document | Perm Sep | Retirement | Transfer Within DGS | Transfer To New Agency | Comments or Submission Deadlines (from the date of separation) |
|---|---|---|---|---|---|
| PAL Time Entry (Not a document) | YES | YES | YES | YES | Review PAL for accuracy of time employee worked. Refer to your ABMS manual. |
| Absence and Time Worked (STD.634) | YES* | YES* | N/A | YES* | *BOARDS AND COMMISSIONS ONLY |
| Employee's Separation Clearance Checklist (DGS OHR 11) | YES | YES | YES | YES | |
| Sep/Disp of CalPERS Contributions (STD.687) | YES | Optional* | NO | NO | *If retiree is going to have an address change. |
| PST Retirement Plan Benefit Payment Application | YES* | YES* | YES* | YES* | *If the employee was Seasonal, Temporary or contributed to PST. Contact Savings Plus |
| Statement of Economic Interests (Form 700) | YES* | YES* | YES* | YES* | *If employee is leaving a position that is designated Conflict of Interest. |

The forms are samples only and shall not be reproduced. It is recommended Attendance Clerk keep a supply of forms. PTU does not provide copies.

# Separation Process *Continue*

**Separation Checklist**

The Separation Document Checklist (DGS OHR-71) may be used as a guideline while coordinating required separation documents for the employee to complete. Documents the employee will complete will depend on the separation type.

The Separation Document Checklist is required for the following separation types:

- Death
- Dismissal
- Rejection from probation
- Resignation
- Service retirement
- Transfer to another State agency
- Transfer within DGS (Review the Checklist to see what forms are required for the intra office transfer.)

The following temporary separations may also require a Separation Document Checklist:

- Disability retirement
- Layoff
- Medical termination

The Separation Document Checklist is to be completed by the AC. The AC may type or use a ballpoint pen. Do not use a pencil.

| | |
|---|---|
| **Section 1** | You shall enter:<br>▪ Employee's full name<br>▪ Agency/Unit number<br>▪ Separation type<br>▪ Separation date<br>▪ Place a checkmark next to forms completed.<br>If the employee is eligible for continuation of benefits, (e.g., COBRA), but the forms are not being submitted with the Separation Package, make a notation when the forms were given to the employee. |
| **Section 2** | The PS will complete this section. |

# Separation Process *Continue*

**Sample of [Separation Document Checklist – DGS OHR 71]**

CLEAR | SAVE | PRINT

STATE OF CALIFORNIA
SEPARATION DOCUMENT CHECKLIST
DGS OHR 71 (Rev. 04/16)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

**Section 1** — **COMPLETED BY ATTENDANCE CLERK**
Complete checklist and return package to OHR AT LEAST FIVE (5) working days prior to separation date.

| EMPLOYEE'S LAST NAME | FIRST NAME | M.I. | ABMS # | AGENCY | UNIT | SEPARATION TYPE | SEPARATION DATE |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

SAMPLE

Check each applicable item as you complete and attach required documents:

- ☐ ABMS SEPARATION ALERT *(Required for all separations, retirements and transfers)*
- ☐ SEPARATION CLEARANCE CHECKLIST DGS OHR 11 *(Required for all Boards and Commissions)*
- ☐ PAL OR TIMECARD (STD. 634) *(Approve PAL first before separating in ABMS)*
- ☐ EMPLOYEE ACTION REQUEST (STD. 686)
- ☐ DENTAL (STD. 692) / VSP (CalHR695) / COBRA (HBD 85)
- ☐ STATEMENT OF ECONOMIC INTEREST (FORM 700)*(If applicable)*
- ☐ LUMP SUM DEFERRAL (DC 3949)
- ☐ SEPARATION/DISPOSITION OF PERS BENEFITS (STD. 687) *(Required for permanent separations, excluding retirements)*
- ☐ PST RETIREMENT BENEFIT PAYMENT APPLICATION (STD. 951) *(Required for permanent separations of eligible employees)*

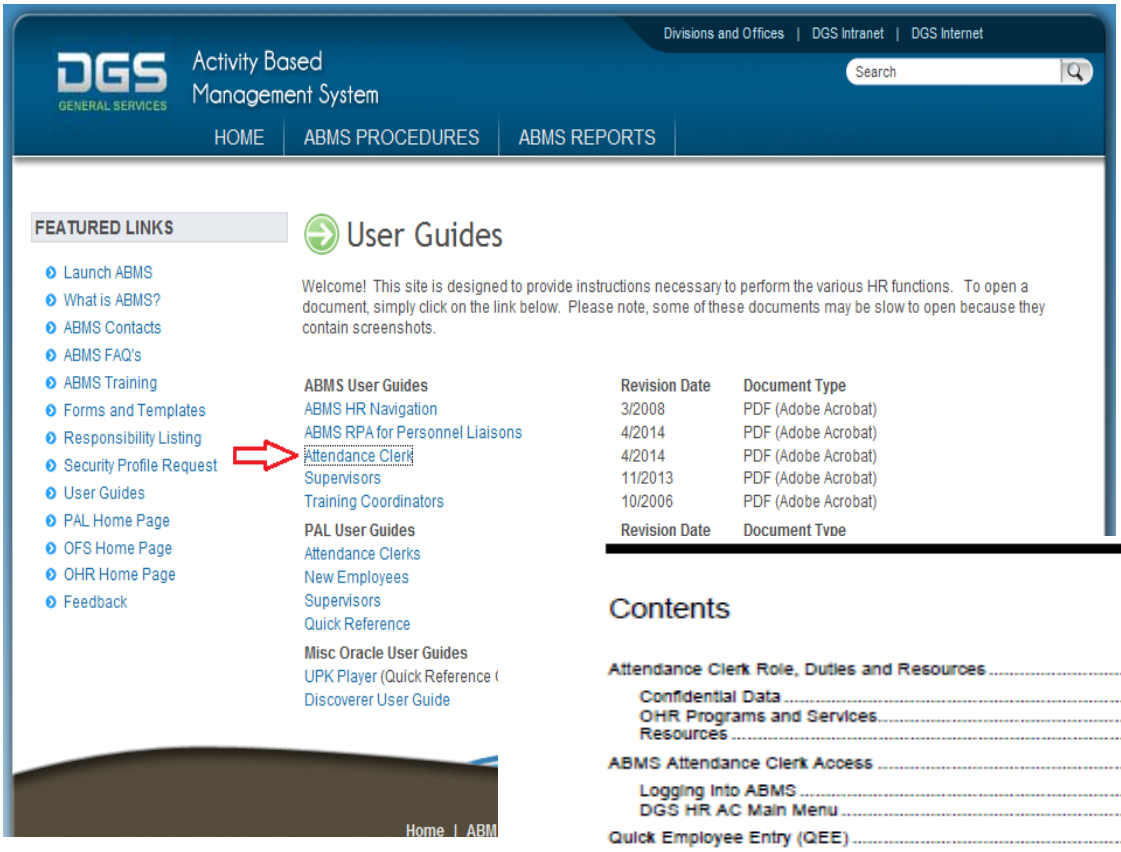
**Section 2** — **PERSONNEL USE ONLY**

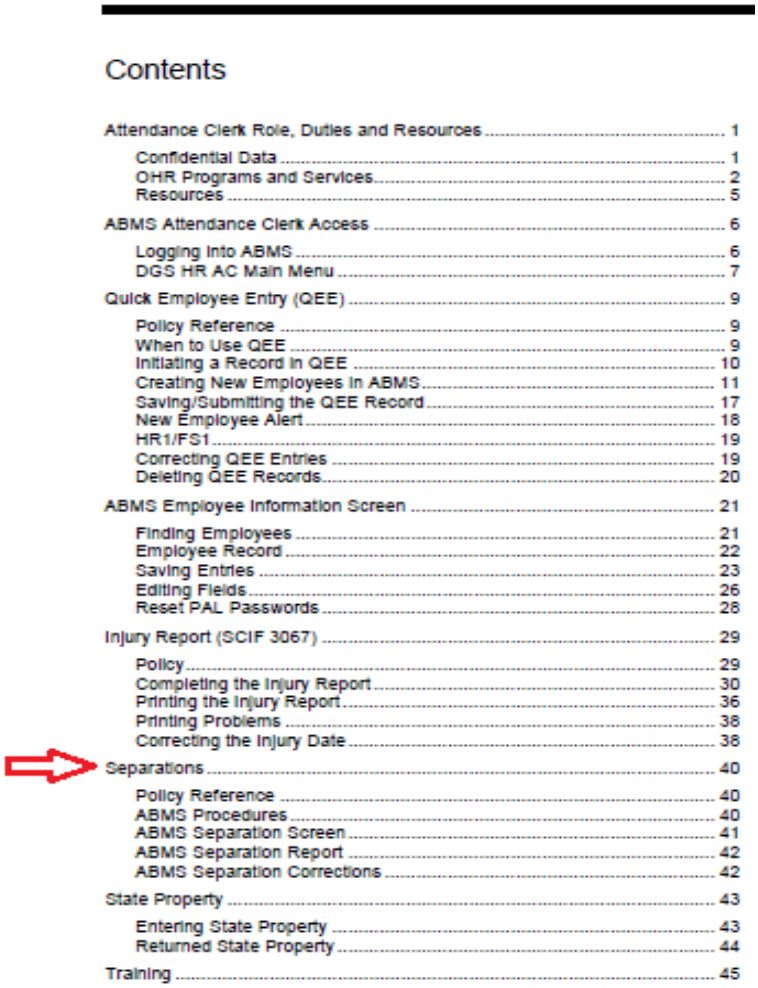
| SEPARATION | COMPLETED: | TRANSFER | COMPLETED: |
|---|---|---|---|
| ☐ Separation Document Checklist | | ☐ Separation Document Checklist | |
| ☐ Separation Doc. Checklist to FI$cal/DGS OHR 11 B&C only contracted FI$cal *(Copy in OPF)* | | ☐ LAS History Printed *(Copy in Separated OPF)* | |
| ☐ Document Your 672 | | ☐ Leave Reconciliation Completed | |
| ☐ LAS History Printed *(Copy in OPF)* | | ☐ PAL/Leave Card Completed and Approved | |
| ☐ Leave Reconciliation Completed | | ☐ PAR Completed/Faxed | |
| ☐ Employee Purged from LAS | | ☐ 612 Completed *(Copy in Separated OPF)* | |
| ☐ Direct Deposit Cancelled | | ☐ Document Your 672 | |
| ☐ PAL/Leave Card Completed and Approved | | ☐ Employee Purged from LAS *(If applicable)* | |
| ☐ Retirement Notification (PERS 197)*(If applicable)* | | ☐ Emergency Information *(Copy in Separated OPF)* | |
| ☐ PAR Completed/Keyed | | ☐ Current Application *(Copy in Separated OPF)* | |
| ☐ EAR Completed | | ☐ A/R Satisfied – Ongoing Forwarded | |
| ☐ Final Pay Received | | ☐ Revolving Fund Cleared | |
| ☐ Salary Advance Request *(If applicable)* | | ☐ Final Pay Released | |
| ☐ ABMS Separation Report Ran | | ☐ Statement of Economic Interest (Form 700)*(If applicable)* | |
| ☐ Revolving Fund/Accounts Receivable Cleared | | ☐ I-9 Original to Gaining Agency *(Retain Copy in Separation OPF)* | |
| ☐ Final Pay Released | | ☐ Retirement Notification for Certificates/Letter from Director | |
| ☐ Check Turnaround in ABMS/Complete PSN Vacancy Date in ABMS | | ☐ Notice of Interrupted Levy/Garnishments Forwarded | |
| ☐ Statement of Economic Interest (Form 700) *(If applicable)* | | ☐ OPF Purged and Placed in Inactive *(With the exception of in house transfers)* | |
| ☐ Dental (STD. 692) to PERS Retirement | | ☐ OPF/PAR & STD 612 Mailed | |
| ☐ COBRA / Retiree Vision or Premier Plan | | | |
| ☐ OPF Purged and Placed Inactive | | | |
| ☐ Key ACA Status Code Cancelling Health Coverage | | | |

# Separation Process *Continue*

## ABMS Separation Alert

Refer to your Oracle Human Resources Training Manual (ABMS) for directions.



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# Separation Process *Continue*

### Completing Project Accounting and Leave (PAL) Time Entry

Refer to your Oracle Human Resources Attendance Coordinator Guide (ABMS) for directions.

*(Boards and Commissions: refer to Boards and Commissions – Absence and Additional Time Worked Time and Attendance -STD.634).*

### Submission

Review the employee's PAL Time Entry before submitting the separation documents to PTU. The employee's supervisor must approve time worked by the employee in PAL before the employee's separation date.

- ✓ DO NOT enter separation information in ABMS if the employee is transferring from one DGS office to another.
- ✓ Leave balance must be reviewed with the employee prior to forwarding the separation package to PTU. The Personnel Specialist cannot reconcile and transfer leave balance to a receiving agency or complete and request the separating employee's lump sum payment if the leave balances are incorrect.

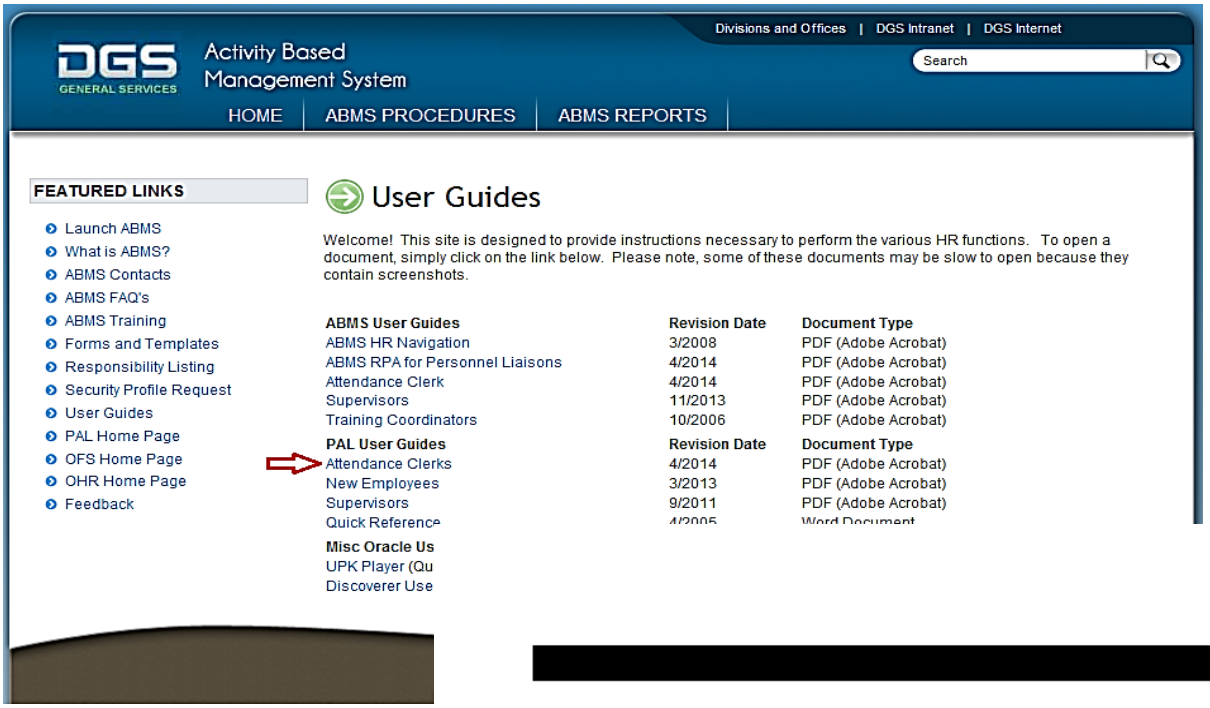
When the employee separates, and/or transfers to another State agency, it is vital that you review the employee's time worked for accuracy. If the time worked is incorrect, the outcome could be a "dock" situation. A "dock" situation is when the employee has been overpaid for time not worked. This results an overpayment to the employee.

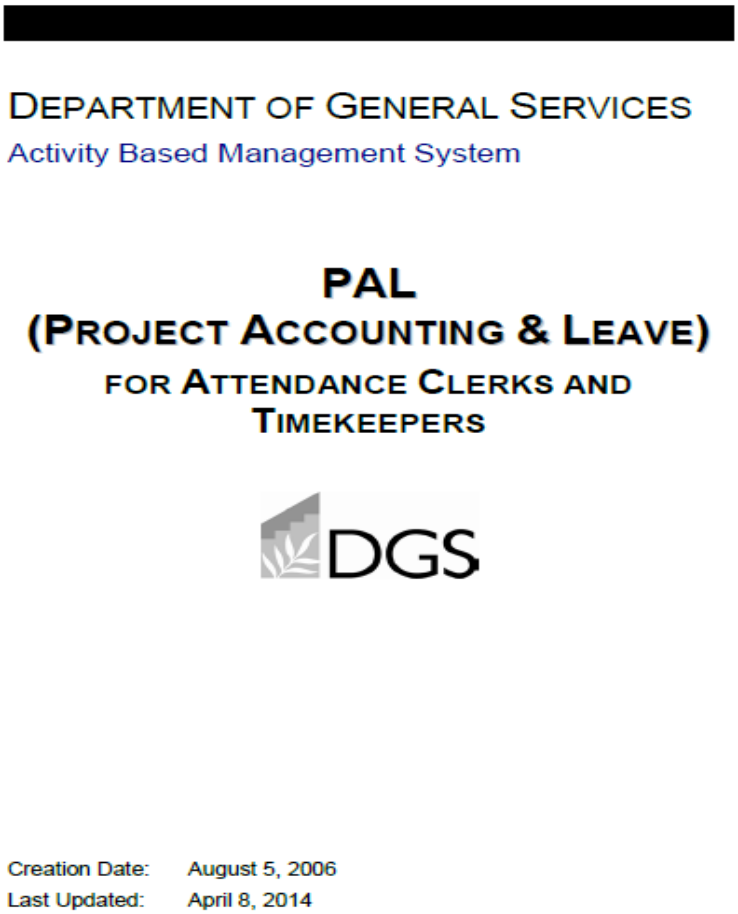
When a dock situation occurs, PTU will need to set up an account receivable to collect the money owed from the employee.

Once the information is entered into ABMS it will execute email alerts to OHR, Fiscal, ETS and BSO.

# Separation Process *Continue*

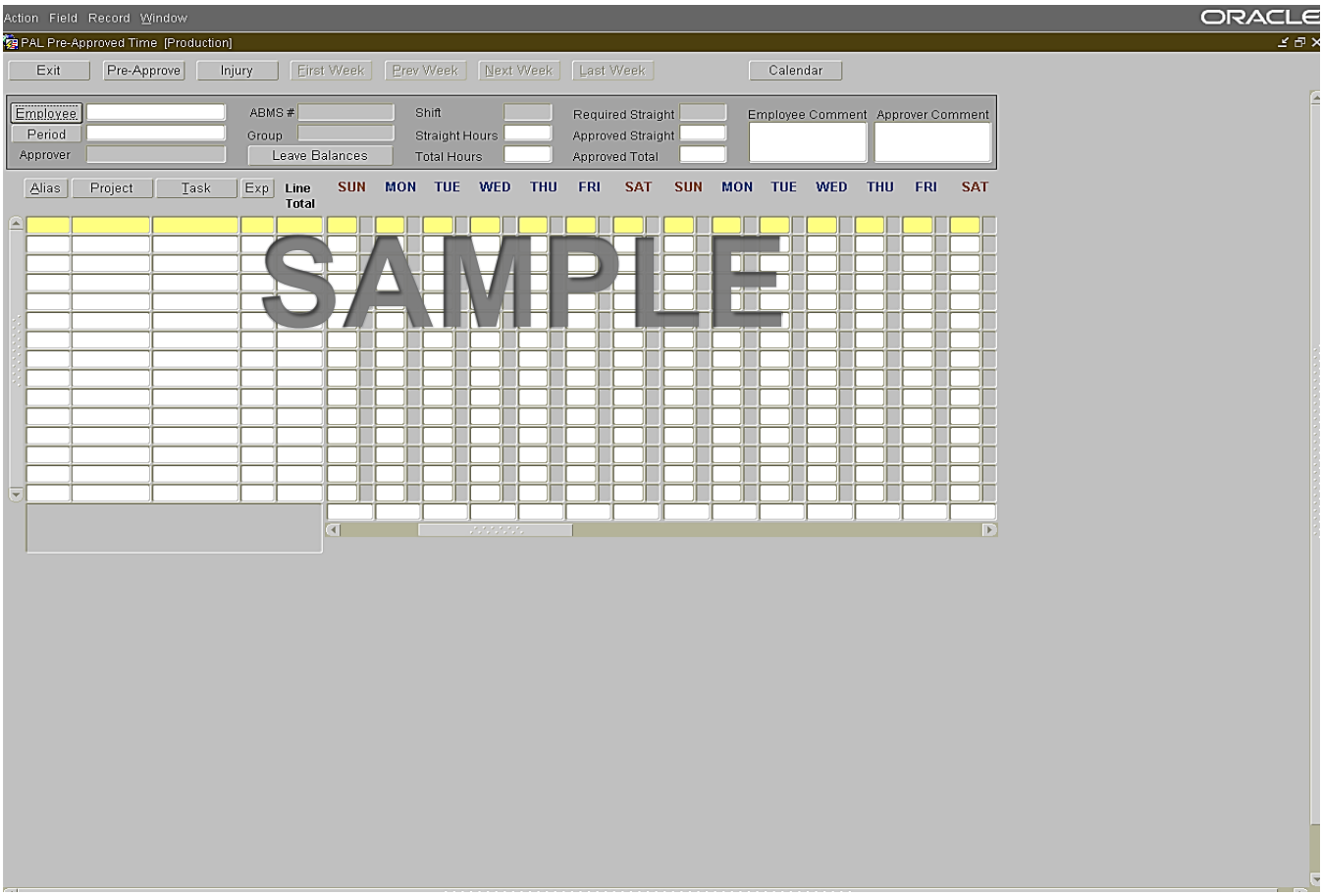
## PAL User Guide



# Separation Process *Continue*

## Sample of PAL Timesheet



# Separation Process *Continue*

**Absence and Additional Time Worked (STD.634) -** *Boards and Commissions only*

Boards and Commissions do not have access to PAL, therefore, an Absence and Additional Time Worked (Absence Request or STD.634) signed by the employee and approved by the supervisor must be submitted at the time of separation.

An Absence Request is required for all separations and transfers even *if no time* was used.

**Submission**

The STD.634 is completed by the employee on or before the last day physically worked. Review the STD.634 for accuracy and clarity for time employee worked.

The employee's supervisor must approve time worked. Attach the approved STD.634 to the Separation Document Checklist and submit to PTU within 5 days of the date of separation.

**Completing the Absence and Additional Time Worked (STD.634)**

The instructions that follow are for separations only. You may assist the employee in completing the STD.634. It may be typed or use a ballpoint pen. Please do not use a pencil. PTU will return STD.634's that have been signed in pencil.

Item #7:

- If the employee separated during the middle of the pay period, draw a line in Item 7A, beginning from the day after the date of separation through the end of the month.
- Intermittent time base: hours the employee worked in the pay period must be posted up to the date of separation.
- Leave credits the employee used in the pay period must be posted up to the date of separation.
- Specify the employee's separating status and date of separation above the line. (E.g., "Transferred to Dept of Education, separated effective mm/dd/yy).

# Separation Process *Continue*

**Completing the Absence and Additional Time Worked (STD.634)** Continue

Item #9:

1. The STD.634 must be signed and dated by the employee. If employee is unavailable to sign, note "Employee unavailable for signature" on a copy of the STD.634 and forward the copy to PTU.

   It is your responsibility as the Attendance Clerk to follow up and forward an original STD.634 with the employee's signature to PTU.

   NOTE: Until the original STD.634 is receive in PTU, the PS cannot reconcile and transfer leave balances to the receiving agency, or compute and request a separating employee's lump sum payment.

Item #10:

1. Employee's supervisor must approve the STD.634 after the employee has signed.
2. The supervisor will sign and date the STD.634.

Return with the Separation Document Checklist within 5 working days after the employee's date of separation.

# Separation Process *Continue*

## Sample of Absence and Additional Time Worked - STD 634 (For Boards and Commissions ONLY)

Print Form | Reset Form

STATE OF CALIFORNIA - DEPARTMENT OF HUMAN RESOURCES

**ABSENCE AND ADDITIONAL TIME WORKED REPORT**

STD. 634 (REV. 2/2014)

TIME BASE | WWG | CB/ID

PAY PERIOD: 1. MONTH | YEAR

SEMIMONTHLY STATUS ONLY: ☐ First Half ☐ Second Half

ALTERNATE WORKWEEK SCHEDULE: ☐ 4/10/40 ☐ 9/8/80

2. NAME (First) (Middle) (Last) | 3. EMPLOYEE ID | 4. POSITION NUMBER

5. ABSENCE WITH PAY

(SL) ☐ SICK LEAVE SELF
(SL) ☐ SICK LEAVE FAMILY ILLNESS
(FH) ☐ FURLOUGH HOURS
(LV) ☐ PLP 2012
(LP) ☐ PLP 2010
(LD) ☐ PERSONAL LEAVE 2003
(PL) ☐ PERSONAL LEAVE
(AL) ☐ ANNUAL LEAVE
(VA) ☐ VACATION

(BL) ☐ BEREAVEMENT LEAVE
(CT) ☐ USING CTO CREDITS (CTO)
(HC) ☐ USING HOLIDAY CREDITS
(EX) ☐ USING EXCESS HOURS CREDIT
(PH) ☐ USING PERSONAL HOLIDAY
(EL) ☐ PAID EDUCATIONAL LEAVE
(PT) ☐ PROFESSIONAL DEVELOPMENT DAY
(HI) ☐ HOLIDAY INFORMAL TIME OFF
(PV) ☐ VOLUNTARY PERSONAL LEAVE
(PA) ☐ PARR

☐ CATASTROPHIC LEAVE
☐ MILITARY LEAVE
☐ (Match Military Duty Orders)
(NDI) ☐ NON-INDUSTRIAL INJURY

**INDUSTRIAL ILLNESS OR INJURY**

(TD) ☐ TEMPORARY DISABILITY
(IDL) ☐ INDUSTRIAL DISABILITY LEAVE
(IDL/S) ☐ INDUSTRIAL DISABILITY LEAVE WITH SUPPLEMENTATION
OTHER

☐ JURY DUTY
☐ ATTENDANCE FEE TO BE REMITTED (Make copy for Accounting)
☐ NO ATTENDANCE FEES RECEIVED

COURT | CITY

(SW) ☐ WITNESS (Make copy for Accounting)
☐ CIVIL CASE ☐ FEES TO BE REMITTED
☐ CRIMINAL CASE ☐ NO FEES RECEIVED
IN THE INTEREST OF/ON BEHALF OF THE STATE: ☐ YES ☐ NO
☐ SUBPOENAED ☐ EXPERT

SAMPLE

6. ABSENCE WITHOUT PAY

(DK) ☐ INFORMAL LEAVE GRANTED (11 Working days or less)
(DK) ☐ INFORMAL LEAVE GRANTED (15 Working days or less) (CSUS)
(DK) ☐ ABSENCE WITHOUT LEAVE (AWOL) (19996.2 or 19572)
☐ TEMPORARY LEAVE (30 Calendar days or less)
☐ ABSENCE WHILE SERVING A PROBATIONARY PERIOD
(FM) ☐ FMLA ☐ CFRA
☐ FMLA MILITARY CAREGIVER LEAVE
☐ PDL

PAY PERIOD IS: ☐ QUALIFYING ☐ NON QUALIFYING

7. DATES OF ABSENCES AND EXTRA TIME WORKED

*(Enter symbol and number of hours in date blocks. See reverse for legends and symbols not noted above. If the absence is for a compensable injury waiting period, add X to other symbol.)*

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7A. HRLY INT/PY HRS TO BE PAID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7B. SICK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7C. BEREAVEMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7D. VACATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7E. A/L | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7F. CT, HC, EX, FM, PH, EL, ML, JD, SW, MN, PL, LV, LP, FH, PV, HI, PT, PA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7G. DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7H. STRAIGHT TIME, P, HC, CT, EX | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7I. PREMIUM TIME CT, P | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

8. REASON FOR ABSENCE OR EXTRA HOURS WORKED

9. CERTIFICATE BY EMPLOYEE

*To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.*

EMPLOYEE SIGNATURE | DATE

10. RECOMMENDATION AND SUBSTANTIATION OF SUPERVISOR ☐ APPROVAL RECOMMENDED ☐ APPROVAL NOT RECOMMENDED

*To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.*

SIGNATURE OF SUPERVISOR | DATE

| 11. PERIOD ON DISABILITY COMPENSATION | | 12. DISABILITY COMPENSATION SUPPLEMENT | | | | | 13. OFFICIAL DEPARTMENTAL ACTION | REVIEWED BY |
|---|---|---|---|---|---|---|---|---|
| FROM | TO | HOURS | SICK LEAVE | VACATION | CTO | HOLIDAY CREDIT | ☐ APPROVED ☐ DISAPPROVED | |

# Separation Process *Continue*

**Employee's Separation Clearance Checklist**
**DGS OHR 11**

The Employee's Separation Clearance Check List (DGS OHR 11) is a DGS form which verifies monies owed to the Department or office, and State property (e.g., DGS credit cards) that must be recovered prior to the employee's receiving the final pay warrant.

The Separation Clearance Checklist is required for separations from State service, and transfers, including from one DGS office to another.

The Separation Clearance Checklist must be returned with the Separation Document Checklist within 5 working days of the employee's separation date.

**Completing the Employees Separation Clearance Checklist**

| | |
|---|---|
| **Employee Information:**<br>**(Attendance Clerk)** | Enter employee's:<br>1. Full name<br>2. Social Security Number<br>3. Office where the employee works<br>4. Position (e.g., janitor)<br>5. Separation date<br>**6.** Separation type or transfer |
| **Section 1**<br>**(Employee's Supervisor or designated staff)** | ✓ Check "Yes" if all property has been returned.<br>✓ Check "No" if all State property has not been returned; enter total dollar amount to be deducted for unreturned property. <u>If no dollar amount is entered, the form will be returned, delaying the employee's final warrant</u>.<br>✓ "Missing Items": Itemize missing property.<br>✓ Supervisor sign and date. |
| **Section 2**<br>**(Attendance Clerk)** | ✓ Check 'Absence Request Completed' when the employee's final attendance is entered in PAL.<br>✓ If employee was serving on jury duty, copy of PAL and original jury duty slips must be forwarded to accounting.<br>✓ Sign and date. |
| **Section 3 (PTU)** | PTU will complete Section 3. |
| **Section 4 (Acct)** | Accounting will complete Section 4. |

# Separation Process *Continue*

## Sample of Employee's Separation Clearance Check List – DGS OHR 11

STATE OF CALIFORNIA

DEPARTMENT OF GENERAL SERVICES

**EMPLOYEE'S SEPARATION CLEARANCE CHECKLIST**

GS 11 (REV. 12/2006)

***Submit original and yellow copy to the Personnel Transactions Unit***

***See Privacy Notice on reverse***

The final salary warrant of a terminating employee MAY NOT BE RELEASED UNTIL:

(1) The attendance clerk has cleared
(2) All items have been cleared, AND
(3) The Check List is completed by Accounting

SAMPLE

| EMPLOYEE | SOCIAL SECURITY NUMBER |
|---|---|
| OFFICE | |
| POSITION | SEPARATION DATE / SEPARATION TYPE |

**1. TO BE COMPLETED BY OFFICE**

ALL STATE PROPERTY, EQUIPMENT, KEY IDENTIFICATION AND CREDIT CARDS HAVE BEEN RETURNED OR PROPERTY ACCOUNTED FOR

☐ **YES, RELEASE** ☐ **NO, HOLD**

| COST | MISSING ITEMS |
|---|---|
| $ | |

| SUPERVISOR'S SIGNATURE | DATE SIGNED |
|---|---|

**2. TO BE COMPLETED BY ATTENDANCE CLERK**

☐ ABSENCE REQUEST COMPLETED ☐ COPY OF ABSENCE REQUEST FOR JURY DUTY

| ATTENDANCE CLERK SIGNATURE | DATE SIGNED |
|---|---|

**3. TO BE COMPLETED BY PERSONNEL OFFICE**

☐ **EMPLOYEE** (Date) _____ ☐ **OUTSTANDING SALARY ADVANCE** (Date) _____ ☐ **OUTSTANDING ACCOUNTS RECEIVABLE $** _____

**TO BE CLEARED BY**

| PERSONNEL ASSISTANT SIGNATURE | DATE SIGNED |
|---|---|

**4. TO BE COMPLETED BY ACCOUNTING**

☐ **TRAVEL ADVANCE CLEARED** ☐ **REVOLVING FUND PAYMENT**

| DEDUCT FROM FINAL PAYCHECK | (Travel) | (Salary) | (Jury Duty) | DATE EMPLOYEE CLEARED |
|---|---|---|---|---|
| | $ | $ | $ | |

| DATE FINAL SALARY WARRANT RELEASED TO ATTENDANCE CLERK | DATE ATTENDANCE CLERK AUTHORIZED TO RELEASE CHECK |
|---|---|

| DISBURSEMENT & COLLECTION OFFICER SIGNATURE | DATE SIGNED |
|---|---|

DISTRIBUTION: Original–Fiscal Services; Copy–Personnel; Copy–Office

# Separation Process *Continue*

## Separation/Disposition of CalPERS STD 687

The California Public Employees' Retirement System (CalPERS – STD 687) is responsible for administering retirement benefits.

The Separation/Disposition of CalPERS Contributions (STD.687) is also referred to as the 'Separation EAR'. It is the legal document for an employee separating from State service (e.g., resignation) excluding service retirement. The Separation EAR is used to report the separating employee's choice for CalPERS contribution election and final mailing address.

The Separation EAR is a multi-faceted document. The first two pages of the Separation EAR have information for the employee's knowledge including rights of CalPERS members and refund tax information. On the reverse side of the employer's copy (yellow) is the Justification for Non-signature of Spouse form and the last page of the Separation EAR is the CalPERS Direct Rollover Election Form. Samples of the forms are included in this section.

Refer the employee to CalPERS for answers to questions regarding their CalPERS contributions.

## Requirements

The guideline below illustrates conditions when the employee is required to complete the Separation EAR.

| **REQUIRED: A Separation EAR is required when an employee:** | **OPTIONAL: A Separation EAR is optional when an employee:** |
|---|---|
| ✓ Resigns from permanent or probationary positions<br>✓ Acceptance of an exempt position and the employee has a right of return<br><br>Requests a CalPERS contribution refund:<br>✓ Upon permanent separation from all positions<br>✓ Movement to an exempt position in which the employee will become a non-CalPERS member.<br><br>Address change for:<br>✓ Permanently separating employee<br>✓ CalPERS member taking a leave of absence for over a year. | ✓ Resigns from an exempt or temporary civil service position and needs to update mailing address. |

# Separation Process *Continue*

**Separation/Disposition of CalPERS Contributions STD 687** Continue

Review the Separation EAR for clarity and that the employee has completed required sections. The Separation EAR must be returned to the appropriate PS with the Separation Document Checklist within 5 working days of the employee's separation date. The PS will key the Separation EAR and forward the employee's copy. A copy will be filed in the employee's OPF.

**Completing the Separation/Disposition of CalPERS Contributions STD 687**

Advise the employee to read and follow the instructions on the Separation EAR. The following instructions and information are intended to supplement the instructions on the Separation EAR.

An employee required (e.g., separating from State service by resigning) to complete the form, shall complete Sections B through G, and must have spouse's signature if a refund of retirement contributions is requested.

If the employee is completing the form optionally**, only** sections B, C, F and G will need to be completed.

If the employee is requesting a refund or roll over of CalPERS contributions, the Waiver or Rights in Section D must be initialed. For a rollover, the Rollover Election Form must be completed and forwarded to CalPERS. A refund or rollover will not be processed by SCO if either is not done.

| | |
|---|---|
| **Section A (Attendance Clerk)** | Enter employee's:<br>▪ 01: Agency code number<br>▪ 02: Unit code number |
| **Section B (Employee)** | ▪ 01: Social Security Number<br>▪ 02: Last name<br>▪ 03: First name and middle initial |
| **Section C (Employee)** | ▪ 01: Separation Date: Enter:<br>▪ The last day the employee physically worked<br>▪ Date leave credits were exhausted prior to separation<br>▪ Date of termination<br>▪ Day prior to retirement effective date<br>▪ 02: Check this box for resignations only. Enter the reason for resignation in the space provided below.<br>▪ 03: Check this box if separation initiated by the Department:<br>✓ Layoffs<br>▪ Expiration of LT or TAU positions when there is no return to former position.<br>▪ Intermittent employees who have failed to accept work in the past 12 months.<br>▪ 04: Check this box for all other actions, including Dismissals and Rejections on Probation. A reason for resignation is not required. |

# Separation Process *Continue*

**Completing the Separation/Disposition of CalPERS Contributions**
**STD 687 Continue**

| | |
|---|---|
| **Section D (Employee)**<br><br>**(Retiring Employees do not complete)** | To terminate membership:<br>▪ 01: Check this box if Federal Income Tax is to be withheld from refund.<br>▪ 02: Check this box if the taxable portion of total contribution is to directly rollover to financial institution or plan of choice. The employee must complete a CalPERS Rollover Election Form and forward the form to CalPERS.<br>▪ Employee must initial the Waiver of Rights – refund or rollover will not process without employee's initials.<br>To continue membership:<br>▪ 03: Check if contributions/service credit will be left on deposit.<br>▪ 04: Check if contributions will remain on deposit due to conditions of reciprocity. Enter the name of the agency as listed in the instructions on the Separation EAR. |
| **Section E (Employee)** | Employee requesting a refund of retirement contributions must complete.<br>▪ 01: Check if elects to have taxes deducted from refund.<br>▪ 02: Check if declining taxes to be deducted. |
| **Section F (Employee)** | ▪ 01-03: Enter the address of the separating employee that wants all future correspondence mailed to. |
| **Section G (Employee)** | Employee signs and date. Spouse's signature is required if a refund of contributions is elected. |
| **Section H** | PTU will complete. |

**Special Instructions for Completing the Separation EAR**

Following are special instructions for completing the Separation EAR.

Additional Positions: Employees with additional positions should complete a Separation EAR when separating from all positions. If the employee is not separating from all positions held, the employee does not have to complete a Separation EAR.

**Section C:**

No Reason Given: If the reason for resignation cannot be obtained, enter "no reason given" in Item C.02.

Employee Unavailable: A signed letter of resignation is acceptable. Enter 'See attached' in Item C.02 (Reason for Resignation), and attach the original letter signed by the employee.

# Separation Process *Continue*

**Special Instructions for Completing the Separation EAR** Continue

Employee Physically Unavailable: If the employee is physically unavailable to complete a Separation EAR or a resignation letter, the office may complete Section C and have a member of the immediate family, the attending physician or a person having power of attorney sign in Section G (Employee Signature). The relationship of the person signing must also be entered in Section G.

Verbal Resignation: If not possible to obtain a completed Separation EAR, enter the information given by the employee in Item C.02 (Reason for Resignation). Also enter "verbal resignation on mm/dd/yy" in Section G (Employee signature).

**Section D**

A refund election form is not valid without:

- The employee's initials following the waiver of rights statement in Section D;
- The employee's signature in Section G;
- The employee's spouse's signature in Section G.

If the employee is not married, or meets one of the criteria listed on the Justification for Non-signature of Spouse form, the form needs to be completed and signed by the employee.

Direct Rollover of Contributions: If the employee elects a direct rollover of contributions, the CalPERS Direct Rollover Election form must be completed by the employee and forwarded directly to CalPERS.

Employee Unavailable: If the employee is unavailable to complete a Separation EAR, do not complete Section D. Advice the appropriate PS the employee was unavailable to complete the Separation EAR.

# Separation Process *Continue*

## Sample of Separation/Disposition of CalPERS Contributions STD 687

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

**SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS**

STD. 687 (REV. 6/2010)

**THE FOLLOWING CONTAINS INFORMATION ON THE RIGHTS OF MEMBERS IF THEY ARE SEPARATING FROM STATE EMPLOYMENT, WHICH INCLUDES ACCEPTING A POSITION AT A PUBLIC AGENCY COVERED BY ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM, CREATING RECIPROCAL RIGHTS**

**NOTE: If you are moving from one CalPERS covered employer to another, you may not withdraw your CalPERS contributions**

**A. NOTICE TO FIRST TIER MEMBERS ELECTING A REFUND OF RETIREMENT CONTRIBUTIONS**

The refund you receive from CalPERS is subject to 20% Federal income tax withholding. Withholding applies only to the portion of your refund that is subject to Federal income tax (i.e., interest your contributions have earned and any tax deferred contributions, if applicable). Whether you elect to receive your refund or roll it over, you have the option of having 2% of the taxable portion withheld for California state income tax. **For additional information on income tax, rollovers, and excise tax, refer to the BAS-500, "IMPORTANT CALPERS REFUND TAX INFORMATION", attached.**

**B. NOTICE TO SECOND TIER MEMBERS WHO ARE TERMINATING EMPLOYMENT**

If you are a vested Second Tier member, and you terminate your employment, your service will be placed in a deferred retirement status without action on your part. When you reach age 55, you will be eligible to receive a retirement allowance from CalPERS. *(You are vested if you have at least 10 years of service credit.)*

**C. ALL MEMBERS WHO ACCEPT EMPLOYMENT COVERED BY A RETIREMENT SYSTEM HAVING A RECIPROCAL AGREEMENT WITH CALPERS**

At present the following are CalPERS reciprocal systems:

- 1937 Act County System (inclusive of Districts affiliated with each County Retirement System):

| | | |
|---|---|---|
| Alameda | Mendocino | San Mateo |
| Contra Costa | Merced | Santa Barbara |
| Fresno | Orange | Sonoma |
| Imperial | Sacramento | Stanislaus |
| Kern | San Bernardino | Tulare |
| Los Angeles | San Diego | Ventura |
| Marin | San Joaquin | |

- The University of California
- Other California Public Agencies:
  Cities of Concord, Costa Mesa (safety only), Fresno, Oakland (non-safety), Pasadena, Sacramento, San Clemente (non-safety), San Diego, and San Jose; East Bay Municipal Utility District, East Bay Regional Park District; Contra Costa Water District; County of San Luis Obispo, and the City and County of San Francisco; Long Beach Schools Business Management Authority; Los Angeles City Retirement System; Los Angeles County Metropolitan Transportation Authority, California Administrative Services Authority.

1. As a member of CalPERS accepting employment covered by one of the reciprocal retirement systems, you will have certain rights if:
   a. You enter employment in which you become a member of a reciprocal system within 6 months after separating from CalPERS-covered employment, and
   b. You elect to leave your contributions on deposit with CalPERS and inform CalPERS of the name of the public agency in which you will be or are employed.
2. The rights of such membership if continued are:
   a. The final compensation used to determine your benefits under CalPERS will be the highest earned under the two systems provided you retire concurrently under both systems;
   b. Your service under all reciprocal systems will be considered to determine eligibility for benefits under the several systems;
   c. The basic death benefit or disability retirement;
   d. A rate of contribution to the public agency retirement system based on your age of entry into membership in CalPERS or another reciprocal retirement system.
3. Contributions you elect to leave on deposit in CalPERS **may not be withdrawn** while you remain in employment covered by one of the reciprocal systems.
4. If you wish to advise CalPERS directly of your election to establish reciprocity, please send written correspondence to the address listed under Section D.

   **NOTE:** Be sure to notify CalPERS of any future address change to ensure delivery of your Annual Member Statement.

**D. ALL MEMBERS WHO ACCEPT EMPLOYMENT COVERED BY THE**

**PRIVACY**

The information you are asked to provide on this form is requested by the Office of the State Controller Personnel/Payroll Services Division. This notice is required by Section 1798.17 of the Information Practices Act of 1977 (California Civil Code Sections 1798 through 1798.76) and the Federal Privacy Act (5 USC 552a, subd (e)(3)) to be provided whenever an agency requests personal information from an individual.

The information on this form is to be used by the State Controller's Office and the Public Employees Retirement System (CalPERS) for the purposes of identification and processing retirement contributions. When authorized by law, address information may be transferred to the following governmental agencies: Internal Revenue Service and Franchise Tax Board. Certain items of information provided on this form may be transferred to the following governmental agencies where authorized by law: Employment Development Department, Department of Social Services, Social Security Administration, Federal Internal Revenue Service, California State Franchise Tax Board, other state income tax bureaus, and other governmental entities when required by state or federal law.

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

**SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS**

STD. 687 (REV. 6/2010)

**IMPORTANT CALPERS REFUND TAX INFORMATION**

The following consists of summarized tax information and is provided in accordance with Section 402(f) of the Internal Revenue Code. ***AS CALPERS CANNOT PROVIDE SPECIFIC INFORMATION OR TAX ADVICE, PLEASE SEE YOUR TAX CONSULTANT, THE INTERNAL REVENUE SERVICE OR THE STATE FRANCHISE TAX BOARD. FOR ADDITIONAL INFORMATION CONCERNING ROLLOVERS, CONSULT THE APPROPRIATE FINANCIAL INSTITUTION OF YOUR CHOICE.***

**ROLLOVERS** - An "eligible rollover distribution" consists of the taxable portion of a refund of your contributions, including interest, due to a separation from all CalPERS-covered employment. You may avoid current taxation on any portion of the taxable amount of an eligible rollover distribution by rolling over that portion into an individual retirement arrangement (IRA) or another qualified employer retirement plan that accepts rollover contributions. A tax-free rollover of the taxable amount of an eligible rollover distribution may be accomplished in one of the following ways:

1) **Direct Rollover** -You may direct CalPERS to transfer all or any portion of the taxable amount of the distribution to a specified IRA or qualified defined contribution plan that accepts rollovers. It cannot be made to another defined benefit plan such as CalPERS. However, the portion to be directly rolled over must be at least $500. Taxes will be reportable when you take the money out of an IRA or other qualified plan.

2) **Regular Rollover** -You may take an in-hand distribution and, **not later than 60 days after you receive the distribution,** transfer all or a portion of the taxable portion of the distribution to an IRA or qualified plan that accepts rollovers. Taxes will be reportable when you take the money out of an IRA or other qualified plan.

Even if you plan to roll over the taxable portion of the eligible distribution, *unless you elect a Direct Rollover, you will only receive 80% of your distribution.* Federal tax rules require CalPERS to automatically deduct 20% federal tax withholding from the taxable portion of your refund, if it is over $200.

If you wish to make the Regular Rollover for the full 100%, you will have to make up the 20% difference out-of-pocket. You will also be taxed on the 20% that was withheld. When filing your individual tax return you then can get a refund of the amount withheld to the extent you have no further tax liability.

Early distributions from a qualified retirement plan are subject to an early withdrawal penalty tax of 10% federal and 2 1/2% State tax on the taxable portion of the distribution PLUS any income tax due on the distribution if it is received prior to age 59 1/2, unless an exception applies.

Please be aware not all distributions are eligible to be rolled over. Any distribution that is part of a series of substantially equal periodic payments made at least annually under a life annuity, over life expectancy or over a specified period of 10 or more years is ineligible to be rolled over. Also ineligible for rollover treatment is the amount of a distribution that is necessary to satisfy the minimum distribution requirements that apply after you separate from employment or you turn age 70 1/2, whichever occurs later.

***EXCEPTION TO THE ADDITIONAL TAX*** - There are some instances where an individual will be exempt from the early withdrawal penalty tax even if he/she takes an early distribution from a qualified retirement plan. These are as follows:

1) receipt of a CalPERS service or disability retirement benefit, paid as a monthly allowance over you/your beneficiary's life; or

2) a lump sum distribution, if made to a beneficiary because of your death; or

3) a lump sum distribution, if made to you because of your separation from service after attaining age 55 or after becoming disabled.

4) Effective 1/1/07 – The 10% Federal penalty tax will be waived when you receive a lump sum distribution, if made to you because of your separation from service after attaining age 50 and you were a safety member who provided police protection, firefighting service or emergency medical services.

***FIVE AND TEN-YEAR AVERAGING / CAPITAL GAIN*** - If you receive a lump sum distribution after you are age 59 1/2, you may be able to make a one-time election to figure the tax on the payment by using ***"5-year averaging"***. To qualify for 5-year tax averaging, you must be at least age 59 1/2 and have participated in CalPERS (the plan making the distribution) for no less than 5 years before the year the distribution is made.

If you receive a lump sum distribution and you were born before January 1, 1936, you can make a one-time election to figure the tax on the payment by using *"10-year averaging"* (using 1986 tax rates). Only one election is available to an individual, and if made, eliminates the ability to elect 5-year averaging and capital gain treatment after attaining age 59 1/2. However, any 10-year averaging election made prior to January 1, 1987, and before attaining age 59 1/2, does not count toward your one election.

If you were born prior to January 1, 1936 and you receive a lump sum distribution, any pre-1974 CalPERS contributions you paid (if applicable) may be taxed as long-term *"capital gain"* at a rate of 20%.

***CALIFORNIA STATE TAX WITHHOLDING*** - Whether you elect to receive a refund OR directly roll over your contributions, you may choose to have state tax withheld or not withheld. State tax, if withheld, is 2% of the taxable portion of the refund. An individual also has the right to revoke or change their choice prior to the mailing of their contributions.

For California residents who do not make a choice, 2% will *automatically* be withheld for State tax even if you elect a rollover.

For **individuals who reside outside of California**, no state tax will be withheld unless specifically requested. Please be aware that you may still owe California state taxes.

Publications are available from the Internal Revenue Service which provide specific information on special tax treatment on lump sum distributions. If you have state tax liability questions, contact the State Franchise Tax Board.

(BAS-500)

# Separation Process *Continue*

## Sample of Separation/Disposition of CalPERS Contributions Continue - STD 687

Print Clear

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

### SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS

STD. 687 (REV. 6/2010)

**Use ballpoint pen and return completed form to your Personnel Office.**

**A — PERSONNEL OFFICE USE**

| 01 AGENCY | 02 UNIT | 03 ADD'L IDENTIFICATION |
|---|---|---|
| | | |

**B**

| 01 SOCIAL SECURITY NUMBER | 02 EMPLOYEE LAST NAME | 03 FIRST NAME AND MIDDLE INITIAL |
|---|---|---|
| | | |

**SEPARATION DATE AND TYPE OF SEPARATION (Check One)**

**C**

01 SEPARATION DATE — MONTH / DAY / YEAR

02 ☐ RESIGNATION — This resignation is executed by me freely and voluntarily and of my own free will and is not given by reason of any threat, force, duress, or any undue influence by any person (Sign in Section G).

03 ☐ SEPARATION WITHOUT FAULT BY DEPARTMENT OR CAMPUS

04 ☐ OTHER

REASON FOR RESIGNATION

**DISPOSITION OF CALPERS CONTRIBUTIONS (Check One Box Only) IF YOU ARE RETIRING, DO NOT COMPLETE THIS SECTION**

**D**

**TO TERMINATE MEMBERSHIP**--To be eligible for a refund you must have service under the first tier and be permanently separating from ALL CALPERS-covered employment. Before checking either box, read the information contained in Section A on the reverse side of the employee copy.

NOTE: A rollover to CalPERS from your Alternate Retirement Program that is administrated by the Department of Personnel Administration will not be allowed if your account has been refunded.

01 ☐ I ELECT TO TERMINATE MY MEMBERSHIP IN CALPERS AND DIRECTLY RECEIVE A REFUND OF MY TOTAL CONTRIBUTIONS. I UNDERSTAND THAT 20% OF THE TAXABLE AMOUNT WILL BE WITHHELD FOR FEDERAL INCOME TAXES AS DESCRIBED IN THE ATTACHED BAS-500 FORM.

02 ☐ I ELECT TO TERMINATE MY MEMBERSHIP IN CALPERS AND DIRECTLY ROLL OVER THE TAXABLE PORTION OF MY TOTAL CONTRIBUTIONS TO THE FINANCIAL INSTITUTION OR PLAN NAMED ON THE CALPERS DIRECT ROLLOVER ELECTION, ATTACHED.

*IMPORTANT:* **NO REFUND OR ROLLOVER OF A REFUND WILL BE PROCESSED IF YOUR INITIALS DO NOT APPEAR AFTER THE WAIVER OF RIGHTS STATEMENT:**

I am aware of my service and disability rights under CalPERS. I have read the description of rights, and the benefit calculation formula and table set forth in the CalPERS member booklet for my classification. Despite my knowledge of these facts, I hereby WAIVE all rights and understand that by requesting a refund, I am forfeiting all future retirement benefits.

(Member's Initials)

**TO CONTINUE MEMBERSHIP** – Contributions, if any, will continue to earn interest, and you will not accrue further service unless you return to CalPERS-covered employment. If you have 5 years of service credit and elect to leave contributions on deposit, you can apply for service retirement at age 50 and receive a monthly allowance. For a retirement estimate, use the "calculator" on CalPERS Website at www.calpers.ca.gov. Before checking either box, read the information contained in Sections B through D on the reverse side of the employee copy.

03 ☐ I ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND LEAVE MY CONTRIBUTIONS AND SERVICE CREDIT ON DEPOSIT.

**NOTE: If you elect to continue membership, you will be required to either refund or retire, if eligible, prior to age 70. Failure to make an election will be deemed an election to refund and a lump-sum distribution will be processed and mailed to your address of record.**

04 ☐ I ELECT TO CONTINUE MEMBERSHIP IN CALPERS AND ESTABLISH RECIPROCITY (AS EXPLAINED IN SECTIONS C AND D ON THE REVERSE SIDE OF THE EMPLOYEE COPY) BY ACCEPTING EMPLOYMENT WITH THE FOLLOWING PUBLIC AGENCY, WHICH PROVIDES MEMBERSHIP IN ANOTHER CALIFORNIA PUBLIC RETIREMENT SYSTEM.

(Enter name of Public Agency / Retirement System / University of California)

**CALIFORNIA STATE TAX WITHHOLDING (Before checking either box, read the information contained in the form BAS-500)**

**E**

I ELECT TO HAVE 2% OF THE TAXABLE PORTION WITHHELD FOR STATE INCOME TAX (APPLICABLE TO OUT-OF-STATE RESIDENTS ALSO)

01 ☐ YES OR 02 ☐ NO

**MAILING ADDRESS: Your Wage and Tax Statement (Form W-2) and any final warrants and/or retirement refund will be mailed to the address entered below.**

**F**

| 01 EMPLOYEE ADDRESS (Street, Rural Route or P. O. Box) | 02 CITY | STATE | 03 ZIP CODE |
|---|---|---|---|
| | | | |

**EMPLOYEE /SPOUSAL/REGISTERED DOMESTIC PARTNER SIGNATURE-Spouse's/Registered Domestic Partner's signature is required for refund election. IMPORTANT-If not signed, the Justification for Nonsignature form must be completed.**

**G**

**EMPLOYEE:** I certify that the above information is true and correct.

| EMPLOYEE'S SIGNATURE | DATE SIGNED |
|---|---|
| | |

**SPOUSE/REGISTERED DOMESTIC PARTNER:** I certify that I am aware of my spouse's/partner's request for a refund of contributions.

| SPOUSE'S/DOMESTIC PARTNER'S SIGNATURE | DATE SIGNED |
|---|---|
| | |

**PERSONNEL OFFICE USE**

**H**

01 ☐ **EMPLOYEE UNAVAILABLE** for completion of Section D. The employee has been advised that he/she must request the disposition of his/her retirement contributions in writing directly from CalPERS.

02 LAST DATE OF CONTRIBUTIONS — MO / DAY / YR

Enter the last date CalPERS contributions were or will be deducted from employee's pay. See instructions in PAM or CSU PIMS Manual.

REASON FOR EMPLOYEE'S UNAVAILABILITY

| REVIEWER'S SIGNATURE | DATE SIGNED | PHONE |
|---|---|---|
| | | |

DISTRIBUTION: WHITE — Personnel/Payroll Services Division YELLOW — Personnel PINK — Employee

SAMPLE

# Separation Process *Continue*

## Sample of Separation/Disposition of CalPERS Contributions Continue - STD 687

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

**SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS**

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### JUSTIFICATION FOR NONSIGNATURE OF SPOUSE OR REGISTERED DOMESTIC PARTNER

Pursuant to Government Code Section 21261, the member's current spouse or registered domestic partner must be made aware of the selection of benefits or change of beneficiary made by a member. The spouse or registered domestic partner of a CalPERS member must acknowledge the submission of a request for refund of contributions.

If a spouse's or registered domestic partner's signature does not appear on the election to terminate CalPERS membership in Section G, the following information MUST be completed by the member.

SAMPLE

| SOCIAL SECURITY NUMBER | MEMBER'S NAME |
|---|---|
| | |

APPLICATION SUBMITTED (Form Name and Number)

**SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS, STD. 687**

- ☐ I am not legally married or do not have a registered domestic partner.
- ☐ I am married, but my spouse or registered domestic partner did not sign the form because:
  - ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or registered domestic partner; OR,
  - ☐ My spouse or registered domestic partner has been advised of the refund application and has refused to sign the written acknowledgement; OR,
  - ☐ My spouse or registered domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition; OR,
  - ☐ My spouse or registered domestic partner has no identifiable community property interest in the benefit; OR,
  - ☐ My spouse or registered domestic partner and I have executed a spousal or domestic partner settlement agreement which makes the community property law inapplicable.

I CERTIFY UNDER PENALTY OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

| MEMBER'S SIGNATURE | DATE SIGNED |
|---|---|
| | |

# Separation Process *Continue*

## Sample of Separation/Disposition of CalPERS Contributions Continue - STD 687

STATE OF CALIFORNIA - CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

**SEPARATION/DISPOSITION OF CALPERS CONTRIBUTIONS**

STD. 687 (REV. 6/2010)

**CalPERS DIRECT ROLLOVER ELECTION FORM**

**IMPORTANT:** The Rollover Election form must be completed and returned to CalPERS. YOUR ROLLOVER ELECTION CANNOT BE PROCESSED UNTIL THIS FORM IS RECEIVED BY CalPERS. Mail to: CalPERS, Section 445, P. O. Box 942711, Sacramento, CA 94229-2711.

DO NOT SUBMIT A TRANSFER FORM FROM YOUR FINANCIAL INSTITUTION IN LIEU OF THE FOLLOWING INFORMATION.

Please either type or print clearly

SAMPLE

| MEMBER NAME | | | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| STREET ADDRESS* | CITY | STATE | ZIP CODE |

DAYTIME TELEPHONE NUMBER

( )

**DIRECT ROLLOVER ELECTION**

ROLL OVER THE TAXABLE PORTION OF MY RETIREMENT CONTRIBUTIONS DIRECTLY TO (Type of Account)

☐ IRA ☐ OTHER ELIGIBLE RETIREMENT PLAN

| INSTITUTION OR PLAN NAME | ACCOUNT NUMBER |
|---|---|

*The rollover warrant will be made payable to your financial institution or plan name and mailed to YOUR address.

I certify that the institution / plan named above is eligible under the provisions of the Internal Revenue Code to accept a rollover by direct transfer and agrees to receive my CalPERS funds and deposit them as indicated.

| MEMBER'S SIGNATURE | DATE SIGNED |
|---|---|

# Separation Process *Continue*

**Part Time-Seasonal Temporary (PST) Retirement Plan**

Part-time, seasonal and temporary employees (PST) who are not eligible for membership in CalPERS, and are not covered by social security, are automatically enrolled in the PST Retirement Plan

The PST Retirement Plan is administered through Savings Plus Program (SPP.)

**Separating PST Employees**

When PST employees separate from employment, they may:

- Request a refund of their contributions;
- Transfer their funds to another employer-sponsored 457 Deferred Compensation Plan.

When PST employees become CalPERS eligible, contributions to the PST plan end, and retirement contributions to CalPERS begin. They may:

a) Request a refund of their contributions;

b) Transfer their PST funds to the Savings Plus Program's (SPP) 457 Deferred Compensation Plan.

Refer the employee to SPP for answers to questions regarding the program **savingsplusnow.com** or by calling **(855) 616-4SPN (4776)**

**Statement of Economic Interest Form 700**

It is the policy of DGS to comply with the requirements of the Fair Political Practices Act which prohibits public officials at all levels from acting on matters in which they have an economic interest.

The Fair Political Practice Commission has the administrative responsibility of the Fair Political Practices Act.

The purpose of the act is to remove from decision-making processes those employees who might profit from a decision they make due to their private interests in investments, business, realty and income.

A Form 700 is required for employees when a transaction moves the employee permanently into or out of a position that is designated as Conflict of Interest.

Exceptions are employees who transfer from one designated class to another or who return as a retired annuitant subsequently after retirement.

# Separation Process *Continue*

**Statement of Economic Interest Form 700** Continue

Each Office Chief has designated classifications or positions having decision-making capability, which may be influenced by personal financial interests.

The Administrative Assistant in your office should have a list of classifications that are designated Conflict of Interest. If not, the Conflict of Interest Filing Officer in OHR responsible for the Form 700 and will be able to provide a list.

Employee's questions regarding the Statement of Economic Interest must be directed to the Conflict of Interest Filing Officer.

Refer to the Fair Political Practices Commission's web site for information regarding the Fair Political Practices Act: http://www.fppc.ca.gov/

**Late Statements**

The employee has 30 days from the date they assume and/or leave office to complete and return the Form 700. A maximum fine of $100 may be imposed for late statements.

***See sample of Statement of Economic Interest 700 in the "Appointment" section of the AC manual.***

# Separation Process *Continue*

**Service Retirement**

CalPERS service retirement is a monthly benefit payable for your lifetime. To retire, state employees must do the following:

a) permanently separate from all DGS covered positions
b) submit a retirement application to CalPERS

The table below identifies the different types of retirement and eligibility requirements for each.

| Retirement Type | Eligibility Requirements |
|---|---|
| Service retirement | CalPERS members must be<br><br>• at least 50 years old and<br>• with a minimum of five years of CalPERS credited service |
| Disability retirement | • must have at least five years of service credit (State Second Tier members must have 10 years)<br>• separated or left the job because of a disability **and** remained disabled since then.<br>• If your disability retirement is approved, the employee will receive a monthly retirement payment for the rest of their life (or until recovered from the injury or illness). |
| Industrial Disability retirement | • If disability is the result of a job-related illness or injury.<br>• If the employee retires, they will receive a monthly retirement payment for the rest of their life (or until they recover from the disabling injury or illness). |

# Separation Process *Continue*

**Service Retirement** Continue

**Employee Responsibility**

All DGS employees approaching retirement are responsible for following the steps outlined below.

- Visit MyCalPERS at www.calpers.ca.gov or
- Submit a Retirement Allowance Estimate Request form; or
- Call CalPERS at 888 CalPERS (or 888-225-7377)
- Begin working on your Service Retirement Application form. This can be found in the publication, A Guide to Completing Your Service Retirement Application which can be found in the CalPERS website.
- Notify his/her immediate supervisor, Attendance Coordinator and Personnel Specialist of their retirement date.

Provide their division's assigned Personnel Specialist with copies of the following:

- Employee Action Request (EAR) if there is a change of address
- Request to Transfer Lump Sum Separation Application form, if applicable
- Important! Request to Transfer Lump Sum Separation Pay application forms must be received by the Personnel Specialist no later than 30 days prior to retirement.

**Attendance Coordinator Responsibilities**

All DGS Attendance Coordinators are expected to follow the steps outlined below.

- Complete the ABMS Separation Alert
- PAL or timecard (STD 634)
- Separation Clearance Checklist ( DGS OHR 11) - (Required for Boards and Commissions)
- Statement of Economic Interest (Form 700)
- Statement Disposition of PERS Contribution (STD 687)
- Lump Sum Deferral form
- Dental (STD 692)
- Vision Service Plan ( STD 700)
- COBRA Health (HBD 85)
- PST Retirement Benefit Payment Application

Complete Separation Document Checklist (DGS OHR-71) and return package to PTU, OHR within five working days of separation.

# Separation Process *Continue*

## Service Retirement Continue

### Sample of Transfer Lump Sum Separation Application form

savingsplus
CALIFORNIA STATE EMPLOYEE 401(k) & 457 PLANS

## Lump Sum Separation Pay Deferral Election Form

Submit this original completed form to your personnel office at least five (5) days prior to separation. Be sure to keep a copy for yourself. However, Personnel Offices request you submit your paperwork 30 days prior to separation of service in order to accommodate necessary discussions that may impact timely completion of the paperwork.

**SECTION I–Participant Information**

SAMPLE

| | |
|---|---|
| Last Name, First Name, MI | |
| Mailing Address | |
| City, State, Zip Code | Daytime Telephone Number |
| Separation Date (mm/dd/yyyy) | Alternate Contact Telephone Number |

**SECTION II–Contribution Information**

* A. Write the amount you will have contributed to each plan for the tax year you separate. If SCO is your pay center, your December contribution from the previous year will be included this year. Do not include the lump sum separation pay you will contribute after you separate.

☐ Pre-tax 401(k) Amount $_____ ☐ Roth 401(k) Amount $_____
☐ Pre-tax 457 Amount $_____ ☐ Roth 457 Amount $_____

* B. Write the amount you elect to contribute to your Savings Plus account from your lump sum separation pay in the relevant boxes below.

| Plan Year | 401(k) | | 457 | |
|---|---|---|---|---|
| | Pre-tax | Roth | Pre-tax | Roth |
| | $ | $ | $ | $ |
| | $ | $ | $ | $ |

* The total amount of Section II Item A and the amount in Item B that is applicable to this tax year cannot exceed the maximum annual contribution limits. Contributions to the 403(b) must be included in calculating 401(k) limits. See savingsplusnow.com for maximum annual contribution limits and details.

**SECTION III–Participant Certification**

I request a contribution of lump sum separation pay in accordance with the Plan Document, Internal Revenue Code and my election above. I take full responsibility for providing my request to my personnel office five days prior to my separation date and understand the terms and conditions of deferring all or a portion of my lump sum separation pay. If applicable, I have attached a copy of my approved Savings Plus Catch-Up document.

I understand that the State of California has the authority to approve or reject this request. I hereby certify under penalty of perjury that the information on this form is true and accurate to the best of my knowledge.

| | |
|---|---|
| Signature | Date |

**Personnel Office Use Only**
*Refer to SCO personnel letters applicable to lump sum pay for instructions on completing the separation PAR. Attach this request with a copy of the separation PAR and, if applicable, the approved Savings Plus Catch-Up document from the employee. Retain a copy with the employee file.* ***Do not submit a copy to Savings Plus.***

**California Department of Human Resources Privacy Notice on Information Collection (rev. 9/15)**
This notice is provided pursuant to the Information Practices Act of 1977. The California Department of Human Resources (CalHR), Savings Plus Program, is requesting the information specified on this form pursuant to California Government Code sections 19993 and 19999.5. The information collected will be used for identification of your account and will/may be disclosed to the Savings Plus Third Party Administrator for processing of your request as indicated on the form. Individuals should not provide personal information that is not requested or required. The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR will not be able to process the action(s) indicated on the form as requested.

**Department Privacy Policy**
The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy at https://www.calhr.ca.gov/pages/privacy-policy.aspx.

**Access to Your Information**
The CalHR Privacy Officer is responsible for maintaining collected records. You have a right to access records containing your personal information we maintain. To request access, contact: CalHR Privacy Officer, 1515 S Street 400N, Sacramento, CA 95811 / 916-324-0455 / CalHRPrivacy@calhr.ca.gov

# Separation Process *Continue*

**Employee Death**

It is the policy of DGS to offer the spouse and/or immediate family of deceased employees all reasonable assistance necessary to complete their final affairs.

Although is not a pleasant thought, we all must face the inevitability of death. In most instances, when a death occurs, families and friends must attend to the affairs of the deceased. Very few of us have taken the time to prepare adequate information to assist our families through the difficult period. In fact, most people are not aware of what must be done after the death of an employee.

The following table depicts the roles and responsibilities to process the separation of a deceased employee.

| Role | Responsibility |
|---|---|
| Employee | • Upon appointment or when there is a change of information, completes required forms (STD 241-beneficiary, STD 243-warrant designation, etc.) |
| Attendance Clerk | • Notify the assigned Personnel Specialist in PTU immediately upon receiving notification of the employee's death<br>• Complete ABMS Quick Exit Alert of the employee's death<br>• Ensure that the final PAL timesheet(s) or STD 634 are completed and approved through the employee's date of death<br><br>Gather, compile and provide the Personnel Specialist with the following information:<br><br>• employee's full name, classification and unit number<br>• the immediate supervisor's name and contact number<br>• last day the employee physically worked<br>• the cause of death (specific cause of death if known, e.g., auto accident, heart attack, etc.)<br>• determine if this was a job related death<br>• name, address, telephone number and relationship of next-of-kin |
| Employee's Supervisor | • Reviews employee's timesheet (PAL) or STD 634 for accuracy, making changes if necessary<br>• Approves timesheet and submits to the PS |
| Accounting Office | • Researches any outstanding travel expense claims, travel advances, salary advances, and accounts receivable<br>• Issues final pay warrant |
| Classification and Pay (C&P) Analyst | • Provides information and support to the Office suffering the loss of an employee |
| Personnel Specialist | • Completes/Mail Condolence Letter<br>COMPLETE REQUIRED FORMS<br>• Deceased Employee Data (PPSD21)<br>• Employee Action Request (EAR) (STD686)<br>• Request for Delivery of Warrant of a Deceased Employee (OAS-17)<br>• Release of Funds and Property of Deceased Persons Pursuant to Letters of Testamentary or Letters of Administration (only required if no STD 243 on file)<br>• Employee Death Processing Checklist |

# Separation Process *Continue*

**Employee Death** Continue

| | |
|---|---|
| Personnel Specialist | CONTACT/NOTIFY APPROPRIATE OFFICES<br>• Governor's Office<br>• DGS Director's Office<br>• CalPERS<br>• Department of Industrial Relations<br>• Disability Transactions Unit (may apply)<br>• Department of Personnel Administration; Savings Plus Program (may apply)<br>• MetLife (may apply)<br>• DGS ORIM |
| Personnel Specialist | PROCESS BENEFITS<br>• Health<br>• Dental<br>• Vision<br>• COBRA<br>Release Final Compensation |

**Absence without Leave (AWOL)**

Absence without leave (AWOL) for five consecutive days, whether voluntary or involuntary, is considered an automatic resignation from state service as of the last day the employee worked. An AWOL-resigned employee may file a request for reinstatement with the California Department of Human Resources (CalHR). Reinstatement will be granted only if the employee provides a satisfactory explanation as to the cause of the absence and his/her failure to obtain leave, and it is found that s/he is ready, able, and willing to discharge his/her duties or has obtained his/her former employer's approval for a leave of absence.

The approval or disapproval of time off should be based on the operational needs of the unit or office and should be consistent with the Memorandum of Understanding (MOU) of the relevant bargaining units.

**Legal Authority**

Under Government Code § 19996.2, an employee who is absent (voluntarily or involuntarily) without permission for five consecutive work days may be considered to have automatically resigned from State service as of the last date on which the employee worked or was on approved time off. An automatic separation may occur in such instances as when the employee:

- does not return from a leave of absence, vacation, sick leave, or other approved time off, and does not obtain a leave extension or does not submit a letter of resignation.
- remains off work without providing requested/appropriate substantiation for an extended period of leave that was tentatively approved pending receipt of substantiation.
- is expected to be incarcerated for more than five consecutive working days.

*NOTE:* AWOL time may be used as a basis for taking formal adverse action

# Separation Process *Continue*

**Absence Without Leave (AWOL)** Continue

**Office Procedures for Requesting Time Off**

Each office should have clear procedures for requesting time off. Employees should be properly and fully informed of these procedures and the potential consequences for failure to obtain approval for absences. The failure to inform an employee about the procedures and consequences could result in the AWOL time being reversed, or the employee being reinstated from an automatic resignation**.**

AWOL separation should be used for those employees who miss five consecutive days of work without obtaining approved leave.

**Supervisor and CIU Responsibility**

Before initiating AWOL separation action, the supervisor must contact OHR and discuss the action with the appropriate Classification and Pay Analyst.

Supervisor and CIU analyst will discuss the events surrounding the AWOL and the likelihood that AWOL will continue.

The CIU analyst will also notify the Personnel Transactions Unit (PTU) of the impending separation so that final pay can be determined and a check prepared for release within 72 hours of the issuance of the AWOL letter.

**Attendance Coordinator Responsibility**

Upon receiving notification from PTU that an AWOL separation action has been initiated against an employee, the Attendance Coordinator must do the following:

- complete the employee's PAL final timesheet(s) or STD 634s for Boards and Commissions as instructed by the PS in PTU
- after completion, ensure that timesheets are approved by the employee's supervisor and/or manager
- confirm AWOL effective date (employee's last day worked)
- key the appropriate ABMS separation transaction

***Note!*** **Please ensure that the correct alias is used when entering the employee's absence on their timesheet. Alias name (A) Absence without Leave is used for an AWOL resigned employee.**

***Important!*** **Do not use alias name (L) Dock for an AWOL resigned employee as Dock is an approved absence without pay.**

**Reminder**

There are variables that could affect the decision to use AWOL. These might include the employee's workweek group, status regarding Family Medical Leave, etc. Thus, it is important that the supervisor contact the CIU **prior to any action** by a supervisor in all AWOL cases.

# Separation Process *Continue*

**Termination of Temporary Authorization Appointments (TAU)**

Temporary Authorization (TAU) is an appointment made in the absence of any appropriate employment list. No person may serve in one or more positions under temporary appointment longer than nine (9) months in twelve (12) consecutive months.

**Expiration Date for TAU**

An expiration date of nine months or less is required when an employee is appointed TAU full time or part time with the employee working a specified fraction of each day in a five day week.

An employee serving on a TAU appointment may be separated at any time prior to the expiration of the term by advising him/her either verbally or in writing of the separation.

**Actual Time Worked**

Actual time worked is a method that can be used to keep track of a TAU employee's time to ensure that the Constitutional limit of nine (9) months in any twelve (12) consecutive months is not exceeded.

An employee gains no status or rights as a result of the TAU appointment. An employee who has had only a TAU appointment **has no reinstatement eligibility.**

**Attendance Coordinator Responsibility**

Upon notification of the employee's TAU appointment expiration, the Attendance Coordinators are expected to follow the steps outlined below:

- notify the assigned Classification & Pay (C&P) analyst and Personnel Specialist (PS) of the termination effective date
- ensure that the PAL final timesheet(s) or STD 634s for Boards and Commissions have been completed, reviewed and approved by the employee's supervisor
- key the appropriate ABMS separation transaction

***Important!*** **Timely notification to the Personnel Specialist in PTU will ensure timely payment of the employee's final warrant.**

# Separation Process *Continue*

**Termination of Limited Term Appointments (LT)**

Limited term appointments are made from civil service employment lists and shall be made only to meet temporary staffing needs. DGS has been delegated the authority to make these appointments subject to the provisions outlined in the Personnel Management Policy & Procedures Manual (PMPPM)

**Expiration Date for LT**

Limited term appointments shall not individually or consecutively exceed one year and up to two years with exceptions.

A limited term employee may be separated at any time prior to the expiration of the term for which appointed by advising the employee either orally or in writing of the separation.

***Note:*** **Legal authority is GC 19080.3 can be accessed via the link below:**

Government Code Section

No time served in a limited term appointment may count toward acquiring permanent status in any position or completion of probation.

***Note:*** **California Code of Regulations Title 2, Section 281**

California Code of Regulations

**Attendance Coordinator Responsibility**

Upon notification of the employee's LT appointment expiration, the Attendance Coordinator must do the following:

- notify the assigned Classification & Pay (C&P) analyst and the Personnel Specialist of the termination effective date
- ensure that the PAL final timesheet(s) or STD 634s for Boards and Commissions have been completed, reviewed and approved by the employee's supervisor
- key the appropriate ABMS separation transaction

# Separation Process *Continue*

**Termination of Intermittent Appointments**

An intermittent appointment is an appointment in which the employee is to work periodically or for a portion of the full time work schedule.

Intermittent employment is irregular or recurring, hourly employment that is less than full time each year. It is used to provide a trained work force available on an “on call” basis to supplement a department’s full time staff in handling peak workloads.

A permanent intermittent employee may work a maximum of 1500 hours in twelve (12) months. The 1500 hours may be counted from the effective date of the individual’s appointment or by calendar year per the department’s (DGS) policy.

SPB Rule 448 provides that intermittent employees not covered by authorized leaves who do not work for one year may be considered to have automatically resigned from the position as of one year from the last day the employee was on pay status.

If you have an intermittent employee whose work is unsatisfactory, the disciplinary process must be used for termination since these employees have status and are entitled to due process.

Upon notification of the intermittent employee’s last day of work, the Attendance Coordinator must do the following:

- notify the assigned Personnel Specialist of the termination effective date
- ensure that the PAL final timesheet(s) or STD 634s for Boards and Commissions have been completed, reviewed and approved by the employee’s supervisor
- key the appropriate ABMS separation transaction

# Separation Process *Continue*

### COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law. The COBRA statute requires that employers with 20 or more employees and maintain group health plans (includes medical, dental, and vision coverage) offer continuation of benefit coverage to covered employees, spouses, *domestic partners (*State of California Legislation, not federal law), and dependent children who lose group plan coverage due to a qualifying event. Plan coverage can be continued for a maximum of 18 or 36 months depending on the qualifying event. Premiums are calculated at 102% of the total group rate and paid by the enrollee on a monthly basis to the plan.

#### Qualified Beneficiary

The term "qualified beneficiary" means, an individual who is eligible to continue group coverage because of a qualifying event. Except for the exception listed below on newborns and adopted children, the individual must be covered under the plan at the time of the qualifying event. If the individual is not covered, he/she is not eligible for COBRA continuation coverage.

Eligible Individuals

- Current employees
- Former employees
- Retired employees
- Spouses*
- Dependent children**
- Newborn or child placed for adoption (deemed a qualified beneficiary, although not covered at time of the qualifying event)

Ineligible Individuals

- Non-resident aliens (with no U.S. income)
- Individuals (not qualified beneficiaries) under the plan because of another qualified beneficiary's election

* Domestic partners (eligible based on State of California legislation, not federal COBRA law).

** National Medical Support Notice (NMSN) and Qualified Medical Child Support Order (QMCSO)

COBRA provides two basic maximum periods of coverage for each type of qualifying event. The two maximum periods specified are 18 or 36 months. The following outlines the qualifying events and maximum length of continuation coverage.

#### COBRA Coverage 18 Months

If the qualifying event causing the loss of coverage is a voluntary or involuntary termination of employment (other than for reasons of gross misconduct) or a reduction of hours (which results in a loss of coverage), then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the loss of coverage.

# Separation Process *Continue*

**COBRA** Continue

**COBRA Coverage 36 Months**

If the original qualifying event causing the loss of coverage was the death of the employee, divorce, termination of domestic partnership, legal separation, or child ceases to be a dependent (e.g., child turns age 26), then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of his/her loss of coverage.

**Employees Benefits and COBRA**

Employees can extend some benefits under the Consolidated Omnibus Reconciliation Act (COBRA). Other benefits end when employees separate or retire. Former employees or their dependents who are eligible and participating in COBRA continuation coverage may change health plans and add/delete eligible dependents during Open Enrollment.

Some benefits differ depending on whether employees separate or retire, as shown in the table below:

| Benefit | If employee is … | Then … |
|---|---|---|
| Health | separating | health coverage will terminate. They may be eligible to extend their benefits under COBRA |
| | retiring | health coverage will automatically continue |
| Dental | separating | dental coverage will terminate. They may be eligible to extend their benefits under COBRA |
| | retiring | Employee to complete/submit dental form to OHR, Personnel Specialist will process the enrollment form to continue coverage |
| Group Legal Services | separating or retiring | coverage ends |
| Long Term Disability Insurance | separating | eligible to convert the LTD plan to an individual policy. Contact the LTD coordinator within 31 days of their separation. |
| Vision Services | separating | eligible to extend their benefits under COBRA. |
| | retiring | eligible for COBRA or Retiree Vision Plan (RVP) |
| Group Term Life Insurance | separating | They can convert the basic and supplemental coverage to an individual policy. Contact MetLife within 31 days of their separation by calling (800) 252-8524. |
| | retiring | they may continue the basic and supplemental coverage at their own expense. Contact MetLife 30 days before they retire @ (800) 252-8524. |
| Employee Assistance Program (EAP) | separating or retiring | their coverage ends. But, if you're using EAP services when the employee separate or retire, they can use the rest of their allotted sessions. Also, they can continue EAP coverage for six months if they were laid off. |
| Flex Elect Medical Reimbursement Account (MRA) | separating or retiring | they can continue to make contributions through the end of the plan year. Submit the STD. 701R to DPA to continue their contributions.<br><br>***Note*: If they don't continue contributing, they can only submit claims for expenses incurred before they separated or retired.** |

# Separation Process *Continue*

**COBRA** Continue

**Cobra Election Notice and Election Form**

The Personnel Specialist will provide an election notice and election form notice to a covered employee, spouse, domestic partner, and covered dependent children (if any), of their right to elect COBRA continuation coverage.

The election notice informs covers individuals that have rights to elect continuation coverage because they will no longer be covered under a group plan. The loss of coverage is resulting from a COBRA qualifying event. Therefore, under provisions of COBRA, all covered individuals have the right to continue coverage for a maximum of 18 or 36 months, depending on the qualifying event. Their COBRA election rights are detailed in the election notice.

The importance of the election notice cannot be understated. Should covered individuals lose group coverage in the future and later claim that they were not aware of their rights to elect COBRA and election period, then the Personnel Office will be able to support that covered individuals who lose coverage were sent an election notice which provided information on their election rights and election period.

Each covered person whether an employee, spouse, domestic partner, or dependent child has independent election rights. If the covered employee does not want to elect COBRA, then the covered spouse, domestic partner, or dependent child have independent rights to elect COBRA continuation coverage.

The COBRA Election Notice contains the following information:

- Details of rights to elect COBRA continuation coverage and responsibilities
- Outline of coverage/notification procedures/premium payment periods
- A COBRA Election Form
- Specific instructions should the individual chose to elect Cobra.

Additional information on COBRA refer to CalHR website: www.calhr.ca.gov

# Separation Process *Continue*

**COBRA** Continue

**Sample of Cobra Election Form**

CalHR-767 Rev. 03/2012

## COBRA ELECTION FORM

| COBRA ENROLLEE INFORMATION | |
|---|---|
| Name | |
| Social Security Number | |
| Address | |
| City, State, Zip Code | |
| Daytime Phone Number (optional) | |

If the enrollee is not the employee, then provide the employee's name and social security number, and your relationship to the employee.

| Name of Employee: | Social Security Number: |
|---|---|
| | |

Relationship to Employee:

| ELECTION TO ENROLL IN COBRA CONTINUATION COVERAGE | |
|---|---|
| Type of Coverage | Check Choice(s) |
| Medical | ☐ |
| Dental | ☐ |
| Vision | ☐ |

Signature of Person Electing COBRA: _____ Date

This election form must be completed and returned by _____ to the address shown below. If mailed, it must be postmarked by the date shown above. If you elect COBRA continuation coverage, then a separate enrollment form must be completed and sent to the plan for each benefit choice. The Personnel Office will assist in the completion of the required enrollment form(s).

| Department Name and Address: | |
|---|---|
| | |
| | |

*LEFT BLANK*

# Attendance Reporting in PAL

This site is designed to provide instructions necessary to perform the various HR functions:

- Describes Attendance Clerks responsibility in reporting time into Project Accounting & Leave (PAL)
- Identifies Alternate Work Week Schedules (AWWS)
- Defines Work Week Groups (WWG)
- Identifies Over Time (OT) and Compensating Time Off (CTO)
- Provide instructions on Correcting Time
- Timely Entry and Approval
- Defines Dock

This section contains the following topics:


| Topic | See Pages |
|---|---|
| Security Profile Request | 366 |
| Quick Reference | 368 |
| Enter Time into PAL | 369 |
| Preapprove Time | 371 |
| EE Doesn't Exist | 372 |
| Alternate Work Week Schedule (AWWS) | 372 |
| Excess Hours | 375 |
| Request Alternate Work Week Schedule | 375 |
| Termination AWWS | 376 |
| Separation of AWWS Employee | 377 |
| Overtime/CTO | 377 |
| Work Week Group (WWG) | 378 |
| Entering OT/CTO | 379 |
| Shift Differential Employee | 380 |
| Shift Interface | 381 |
| Correcting Time Entry | 381 |
| Correction to Time Report/Project Accounting and Leave (PAL) | 384 |
| Changes to Service Revolving Fund & Architectural Revolving Fund (SRF/ARF) Projects | 384 |
| Timely entry/Approval | 386 |
| Attendance Clerk Role | 387 |
| Detail Instructions for PAL Timesheets | 387 |
| Absence During Time of Approval | 387 |
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| PAL Alerts | 389 |
| Absence/Additional Time Work Report | 390 |
| Dock | 393 |

# Attendance Reporting in PAL

**Security Profile Request**

The PAL Attendance Clerk responsibility in PAL was designed to provide the Attendance Clerks with instant access to view, enter, and pre-approve timesheets on employees working in their assigned Reporting Units.

In order to obtain this access, the HR Security Profile Request (DGS OHR 2) must be completed and approved by your Office/Branch Chief.

Requests for Human Resources applications are to be sent to the Office of Human Resources (OHR). The OHR 2 can be found on the ABMS website at http://inside.dgs.ca.gov/abms/FormsandTemplates.aspx

Requests should be sent to:

Office of Human Resources
Attn: HR-ABMS Security Administrator
707 3rd Street, 7th Floor (IMS Z-1)
West Sacramento, CA 95605

# Attendance Reporting in PAL

## Sample of HR Security Profile Request DGS OHR 2

Clear | Save

STATE OF CALIFORNIA
HR SECURITY PROFILE REQUEST
DGS OHR 2 (Rev. 06/16)

DEPARTMENT OF GENERAL SERVICES
Office of Human Resources

MAIL SIGNED ORIGINAL TO:
DGS/Office of Human Resources
P.O. Box 989052, MS 402
West Sacramento, CA 95798-9052
Attn: OHR ABMS Security Administrator

***** Please submit the original signed OHR-2 to the address above to prevent delays in processing.**
***** DO NOT fax or submit copies. DO NOT submit to the ABMS team.**

### 1. EMPLOYEE INFORMATION

| NAME | | ABMS NUMBER (Required) |
|---|---|---|
| DIVISION/OFFICE | BPM REGION (If applicable) | WORK PHONE |
| POSITION NUMBER | CLASSIFICATION | WORK LOCATION |
| REASON FOR ACCESS (Adding / Changing access only) | | NAME OF PERSON BEING REPLACED (If applicable) |

SAMPLE

### 2a. ABMS ACCESS

ACTION
- ☐ ADD
- ☐ CHANGE
- ☐ REMOVE

TYPE OF ACCESS (Check One)
- ☐ PERSONNEL LIAISON
- ☐ ATTENDANCE CLERK
- ☐ TRAINING COORD
- ☐ OTHER:

ABMS ACCESS TO EMPLOYEES IN (Complete One)
- ☐ OFFICE NAME:
- ☐ BPM REGION:
- ☐ AGY/UNIT(S):

### 2b. PAL ACCESS

ACTION
- ☐ ADD
- ☐ CHANGE
- ☐ REMOVE

TYPE OF ACCESS (Check One)
- ☐ PERSONNEL LIAISON
- ☐ ATTENDANCE CLERK
- ☐ TIMEKEEPER
- ☐ OTHER:

PAL ACCESS TO EMPLOYEES IN (Complete One)
- ☐ OFFICE NAME:
- ☐ BPM REGION:
- ☐ AGY/UNIT(S):

### ABMS SUPERVISOR ACCESS

ABMS supervisor access is automatic. Login with your PAL username and the initial password of the last 4-digits of your SSN plus a zero.

### PAL SUPERVISOR ACCESS

- PAL APPROVAL: This form is not required to approve PAL.
- ☐ I need access to post time for my employees.

SUPERVISORS: If you cannot access your employees in ABMS or PAL, have your Attendance Clerk update the supervisor field on your staff's ABMS records.

### 3. EMPLOYEE STATEMENT OF UNDERSTANDING

- ☐ I hereby acknowledge receipt and have read and understand the provisions and restrictions contained in the DGS-ABMS Security Guidelines provided with this document. (Employee should retain for his/her records.)
- ☐ I fully understand that any violations of security policies and procedures are subject to disciplinary action. Immediate corrective action may result in revocation of access to the Confidential Human Resources Personnel data of the Department of General Services (DGS-ABMS). Any violation of the California Information Practices Act (1977) may also result in criminal and/or civil action.
- ☐ I also understand that unauthorized access, attempting access or use of any computer systems and/or data of the State of California is a violation of Section 52 of the California Penal Code, and is subject to prosecution.

| EMPLOYEE SIGNATURE | DATE |
|---|---|

### 4. AUTHORIZED SIGNATURE

I attest this is an employee of DGS who requires access to ABMS and/or PAL for their assigned duties to this Office/Branch. She/he must have access to confidential HR Personnel data in order to perform legal, statutory and/or government duties.

| OFFICE/BRANCH CHIEF SIGNATURE | DATE |
|---|---|
| CONTACT PERSON FOR THIS HR-1 REQUEST | WORK PHONE |

**Do not submit Security Guidelines on pages 2 – 5 with original signed OHR-2 form.**

# Attendance Reporting in PAL *Continue*

**Menu Quick Reference**

| | |
|---|---|
| Enter Time | Allows the AC to enter or correct his/her PAL time and time for employees within his/her assigned reporting units. |
| Change Password | Allows the AC to change his/her PAL password. Cannot be used to change other employees' passwords. |
| Define Aliases | Allows the AC to create Personal Aliases, default aliases, and set the order of the aliases for his/her PAL timesheet. |
| My ABMS Information | Displays only the AC's information as indicated in ABMS. |
| Pre-approved Time | Allows the AC to enter or correct PAL time for employees within his/her assigned reporting units. This screen approves the time without being submitted to the supervisor. |
| Employee Aliases | Allows the AC to create Personal Aliases for his/her timesheet as well as employees within his/her assigned reporting units. |

# Attendance Reporting in PAL *Continue*

**Enter Time**

The Enter Time screen is used to enter time for yourself or enter and/or submit time for other employees in your assigned units.

The process to enter your own time is not provided in this manual as it is implied that the Attendance Clerk is already familiar with these steps. For detailed information on entering your time, refer to the PAL User Guide for New Employees found on the PAL website at http://inside.dgs.ca.gov/abms/Home.aspx.

The Enter Time screen should be used as a last resort to enter another employee's time. The PAL timesheet is the official timekeeping record and can be challenged by the employee in a legal dispute. When the employee challenges the record, it is OHR's responsibility to report the employees that completed and approved the timesheet for questioning. Therefore, it should only be used to enter time for another employee when:

- The employee is not available to enter or correct his/her time, AND
- There is no other official timesheet or time card and a supervisor's approval is needed.

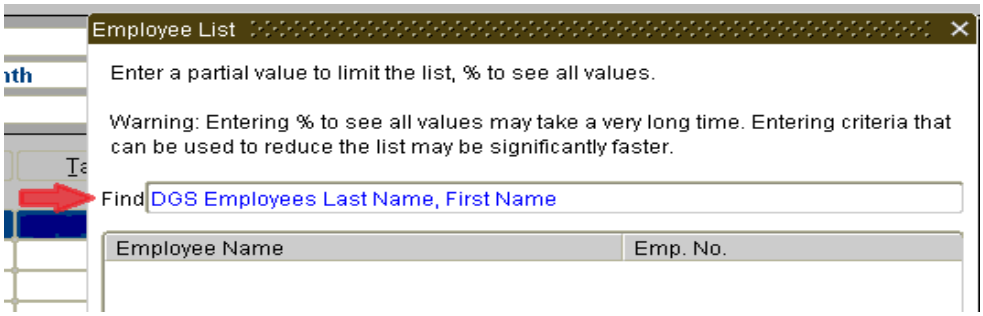
If the employee is required to complete a time sheet/card outside of PAL that is approved by the supervisor, it should be entered into PAL through the Pre-approved Time screen. This screen allows the Attendance Clerk to enter and approve time without submitting it to the supervisor for approval. To use the Pre-Approved Time screen, refer to the Pre-approved Time section later in this section.

To enter and/or submit time for another employee, follow these steps:

1. Click the "Enter Time" button

2. Click on the list of values button with the 3 dots next to your name

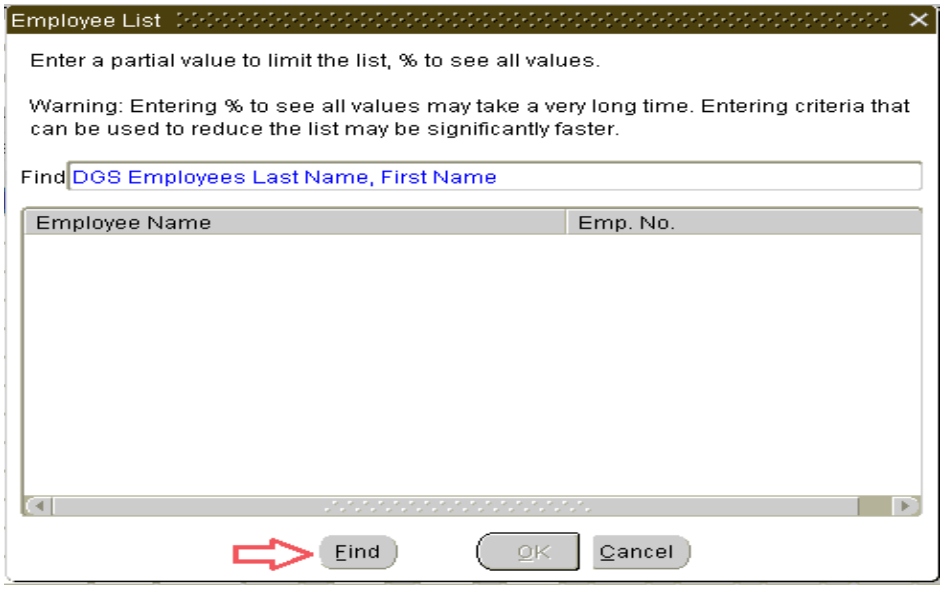
3. When the Employee List window appears, type the last name of the employee you wish to access in the Find field.



# Attendance Reporting in PAL *Continue*

**Enter Time** Continue

4. Click the “Find” button at the bottom of the screen. If an employee list appears, click on the employee’s name and press the OK button at the bottom of the screen to retrieve the timesheet.




5. Enter/submit the employee’s time in the same manner you would for your own PAL timesheet.
6. Provide the employee with a screen print of the employee’s PAL timesheet for his/her records.

# Attendance Reporting in PAL *Continue*

**Pre-Approved Time**

The Pre-Approved Time screen allows you to access an employee's timesheet, enter and approve time without routing the timesheet to a supervisor. This screen was created to enter time for employees that complete a hard copy time report (i.e.; Std. 634, time card, etc.). These documents have already been approved by the employees' supervisor. Therefore, when entering time through the Pre-approved Time screen, the system approves the time immediately without routing it for the supervisor's approval.

Entering time through the Pre-approved Time screen is relatively the same process as the Enter Time screen. The only differences are:

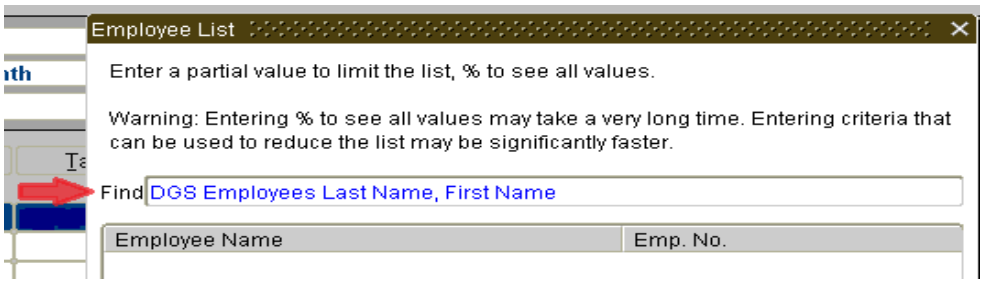
- Attendance Clerks cannot access his/her own timesheet. Another employee must be selected using the dropdown button to the right of the Employee field.
- The row highlight color is yellow instead of navy blue.
- There is a Pre-approve button instead of a Save button.

To enter Pre-approved time for another employee, follow these steps:

1. Click the "Pre-approve Time" button

2. Click on the "Employee" button next to the blank field this will open the Employee List window.

3. When the Employee List window appears, type the last name of the employee you wish to access in the Find field.



# Attendance Reporting in PAL *Continue*

**Pre-Approved Time** Continue

4. Click the “Find” button at the bottom of the screen. If an employee list appears, click on the employee’s name and press the “OK” button at the bottom of the screen to retrieve the timesheet. The Pay Period will default to the current month.
5. Enter the employee’s time, exactly as it is on the paper document, in the same manner you would for your own timesheet.
6. When all time is entered, press the Pre-approve button at the top of the timesheet. This changes the status fields to Approved.

**Cannot Find Employee**

If you are unable to retrieve your employee in Employee Name field, it is either because he/she is not within your assigned reporting units, or does not have a position number on his/her ABMS record or is in a BPM position that uses Maximo project/task information.

If you have access to the ABMS Employee Information screen, try retrieving your employee there. If you can access the employee, check the position number. If the record reflects the employee’s position number, and it is in one of your assigned reporting units, contact an ABMS Team for assistance. If no position exists, you will not be able to create the personal aliases until it is entered by your OHR PTU Specialist.

**Alternate Work Week Schedule**

Alternate Work Week Schedules (AWWS) are work schedules other than the conventional eight-hour day, five-day week schedule. They are a fixed, daily work schedule which begins or ends outside official office hours. Start times range between 6:00 a.m. and 9:00 a.m. and stop times normally range between 3:00 p.m. and 6:00 p.m.

Our department recognizes two AWWS: 9/8/80 and 4/10/40. These schedules require special handling in PAL to ensure employees are properly reporting leave usage and earnings and that they are properly compensated for overtime.

To participate and remain in the AWWS program, the employee must have and maintain a cumulative balance of at least twenty (20) hours between vacation/annual leave, compensating time off (CTO), and excess hours (EH) and must agree on the terms and conditions on the DGS 64.

# Attendance Reporting in PAL *Continue*

**9/8/80 Schedule**

A 9/8/80 schedule is a fixed, recurring set of eight 9-hour days and one 8-hour day for a total of 80 hours in a 2-week period. The eight hour day is split (4/4) to reflect the beginning and end of the 40 hour work week as shown below:

| SUN | MON | TUE | WED | THU | FRI | SAT |
|---|---|---|---|---|---|---|
| | 9 | 9 | 9 | 9 | 4 / 4 | |
| | 9 | 9 | 9 | 9 | RDO | |

In the example above, Friday is the alternating day off. This shall be a full 8-hour day the first week, and the RDO the following week. For the purposes of determining overtime, the work week ends mid-day on Friday. This is the completion of the first 40 hour work week (9 X 4 + 4 = 40). The following work week begins the 2nd half of the 8 hour day on Friday through midway of the RDO.

To record the 9/8/80 schedule in PAL, employees must report four 9-hour days and an 8-hour day in the 1st week followed by a 2nd week of four 9-hour days with an additional 4 hours posted to the RDO alias. This special entry in PAL ensures that employees working overtime will be compensated at premium rate.

The example below reflects a 9/8/80 schedule with an alternating Friday off.

| Alias | Project | Task | Exp | Line Total | SUN Aug 10 | MON Aug 11 | TUE Aug 12 | WED Aug 13 | THU Aug 14 | FRI Aug 15 | SAT Aug 16 | SUN Aug 17 | MON Aug 18 | TUE Aug 19 | WED Aug 20 | THU Aug 21 | FRI Aug 22 | SAT Aug 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RDO | AWW-Alternate | RDO | STD -S | 4 | | | | | | | | | | | | | 4 | |
| | INDIRECT | 4 | STD -S | 80 | | 9 | 9 | 9 | 9 | 8 | | | 9 | 9 | 9 | 9 | | |

The RDO alias may be selected by:

1. Entering ‘RDO’ (in capital letters) in the Alias field.
2. Then the TAB key must be selected in order for the project, task and expenditure type to be populated

# Attendance Reporting in PAL *Continue*

### 4/10/40 Schedule

The 4/10/40 schedule is a fixed, recurring set of four 10-hour days each week. The employee's work week shall begin on Sunday at 12:00 a.m. (midnight) and end on Saturday at 11:59 p.m.

To record a 4/10/40 schedule in PAL, the employee will post four 10-hour days each week. There is no need to post the RDO alias for the 4/10/40 schedule.

The example below reflects a 4/10/40 schedule with Fridays off:

| Alias | Project | Task | Exp | Line Total | SUN Aug 10 | MON Aug 11 | TUE Aug 12 | WED Aug 13 | THU Aug 14 | FRI Aug 15 | SAT Aug 16 | SUN Aug 17 | MON Aug 18 | TUE Aug 19 | WED Aug 20 | THU Aug 21 | FRI Aug 22 | SAT Aug 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RDO | AWW-Alternate | RDO | STD -S | 0 | | | | | | | | | | | | | | |
| | INDIRECT | 4 | STD -S | 80 | | 10 | 10 | 10 | 10 | | | | 10 | 10 | 10 | 10 | | |

Excess hours are earned/used based on the number of straight time hours required for the pay period minus the total number of straight hours worked for the pay period.

For example: If the required number of hours for the pay period is 176 and the employee works 177 hours as a result of the AWWS, the employee is entitled to one excess hour for the pay period.

Excess hour earnings and usages are **posted on the last working day** of the pay period. Excess hours are earned when the employee works his/her normal AWWS and exceeds the number of hours required for the pay period. Credits earned due to an excess month are earned at the completion of the pay period and are not available for use until the first of the following month.

Excess hours earned are posted to the last working day of the pay period using the 'EH-EARN' alias. The alias may be selected from the Alias list of values or by entering EH-EARN (in capital letters) in the Alias field. Press the TAB key after entering the EH-EARN alias to populate the correct Project, Task and Expenditure Type.

The following sample displays the correct entries when an employee works more than the required number of hours for the pay period.

| Alias | Project | Task | Exp | Line Total | SUN Aug 27 | MON Aug 28 | TUE Aug 29 | WED Aug 30 | THU Aug 31 | FRI |
|---|---|---|---|---|---|---|---|---|---|---|
| RDO | AWW-Alternate | RDO | STD -S | 8 | | | | | | |
| | INDIRECT | 4 | STD -S | 187 | | 9 | 9 | 9 | 9 | |
| EH-EAR | LEAVE | EX05 | STD -S | 1 | | | | | 1 | |

# Attendance Reporting in PAL *Continue*

### Excess Hours Used (TE-USED)

Excess hours are used when the employee works his/her normal AWWS and does not meet the number of required hours for the pay period.

Excess hours used are posted to the last day of the pay period using the 'TE-USE' alias. If the employee does not have a sufficient number of excess hours to make up the difference for the hours required in the pay period, another available leave benefit may be used with the exception of sick leave. Refer to the PAL Global Leave Alias chart on the PAL website for the correct alias when using another leave benefit in lieu of excess hours.

The following sample displays the correct entries when an employee does not meet the required number of hours for the pay period.

| Alias | Project | Task | Exp | Line Total | SUN Aug 27 | MON Aug 28 | TUE Aug 29 | WED Aug 30 | THU Aug 31 |
|---|---|---|---|---|---|---|---|---|---|
| RDO | AWW-Alternate | RDO | STD -S | 8 | | | | | |
| | INDIRECT | 4 | STD -S | 187 | | 9 | 9 | 9 | 9 |
| TE-USED | LEAVE | EX01 | STD -S | 7 | | | | | 7 |

### Request AWWS

An employee submits an Alternate Work Week Schedule Request and Agreement, DGS-64 to his/her supervisor with a completed copy of the appropriate calendar attached and submits to his/her supervisor for review and approval **thirty days** prior to the effective date, which is the beginning of the next pay period following the 30-day notice. If the employee is already participating in the AWWS, s/he and his/her supervisor **must** submit a new AWWS request and calendar at the beginning of each calendar year.

AWWS calendars can be found: http://www.dgs.ca.gov/ohr/Resources/AlternateWorkweekSchedule.aspx

- The AWWS request will be reviewed by the employee's immediate supervisor and coordinated with the second-level supervisor to ensure the DGS' operational needs are being met.
- If approved, the supervisor and employee must sign the DGS-64.
- The Office's attendance clerk will submit a copy of the AWWS request and calendar to the Personnel Transactions Unit (PTU) to be filed in the employee's Official Personnel Folder (OPF). (The supervisor and employee should retain a copy of the request and calendar).
- If disapproved, the supervisor **shall** notify the employee in writing of the reasons for the denial.

# Attendance Reporting in PAL *Continue*

**Request AWWS** Continue

WWG E/SE employees cannot be approved for alternate work schedules. However, a flexible work schedule may be requested by the employee and mutually agreed upon by the employee's supervisor.

If a WWG E/SE employee is granted a flexible schedule, the employee shall **not**:

- Use the RDO alias
- Post earnings to Excess Hours

Remember, WWG E/SE employees are 'salaried' and work an average work week of 40 hours. They are not eligible for overtime nor are they eligible to earn Excess Hours.

When a WWG E/SE employee is working an authorized flexible schedule and is absent from work for a full week as a result of paid leave (i.e.; vacation, jury duty, union leave or disability leave), these absences must be reported in a full work week based on his/her time base (i.e., a Full Time employee is required to report five 8-hour days for a full 40 hour work week.)

**Termination of AWWS**

An AWWS may be terminated by (refer to the MOU regarding required notice time):

- **The employee.** An employee who wishes to terminate his/her AWWS must submit a signed, written notice including a projected termination date, which **shall** be the end of the pay period.

- **The Office Chief upon recommendation of the employee's supervisor.** If the supervisor determines that operational needs are being impaired or the work hour schedule is being abused, s/he may give written notice to the affected employee to terminate or make permanent changes to the AWWS.

- **The Supervisor.** If an employee has been on dock three pay periods during a calendar year, the Supervisor may terminate the AWWS. Employees who lose eligibility to participate in the alternate work schedule for this reason **may** reapply after a period of six months following reversion to the 5/8/40 work schedule and meeting all other criteria

**Temporary Termination**

A full time employee who is serving jury duty or pending approval of a SCIF or NDI claim beyond the required waiting period **shall** temporarily revert to a 5/40 (8-hour day) schedule until s/he returns to work. The SCO recognized only 8-hour days for reimbursement of these benefits

# Attendance Reporting in PAL *Continue*

**Separation of an AWWS Employee**

AWWS employee is leaving the department in the middle of the pay period you must:

1. Convert back to a 5/8/40 work week until the date of separation. **OR**
2. Be sure that the employee has worked the appropriate number of hours through the employee's separation date.

To determine this, count the total number of work days from the beginning of the pay period including the employees RDO. Multiply that number by eight (the employee's time base). This will provide you the total number of hours required through the separation date.

> For example if the employee's last day of work is July 21, 2006 the hours required for the period is 120 hours (15 days X 8 hours = 120 hours). If the employee's RDO is the 7th and 21st of the month the employee would have worked 116 hours. This would mean the employee needs to use 4 hours of excess time to meet the required number of hours for the pay period.

Failure to post the additional hours will generate PAL alerts to the supervisor reflecting the status of the employee's timesheet with NOT ENOUGH time.

**Overtime/CTO**

Overtime is generally defined as authorized time worked in excess of the regularly scheduled work week.

- Government Code 19843-19844, 19851-19852
- Collective Bargaining Agreements
- DPA's FLSA Manual
- Personnel Operations Manual (POM) on the OHR Website Section: Work Week Groups (WWG)

It is State policy that the work week shall be 40 hours, and the employees' work day is eight hours. This period is a fixed regular recurring period of seven consecutive 24 hour days (i.e.; Sunday through Saturday below).

| SUN (1) | MON (2) | TUE (3) | WED (4) | THU (5) | FRI (6) | SAT (7) | TOTAL |
|---|---|---|---|---|---|---|---|
| | 8 | 8 | 8 | 8 | 8 | | 40 Hours |

Overtime occurs when an employee works more than 40 straight hours in the fixed work week, and <u>not</u> after eight hours in a work day.

Generally, FLSA requires one and one-half cash or compensating time off (CTO) for each overtime hour worked for those employees covered by the Act. Under the provisions of FLSA, the time spent by employees on paid leave such as vacation, sick leave, holidays, compensating time off, etc., need not be counted as time worked. Thus, when an employee works more than 40 hours in a work week that includes paid leave, an overtime payment, at straight rate, may be incurred.

# Attendance Reporting in PAL *Continue*

### Work Week Groups

Overtime compensation is regulated by the Fair Labor Standards Act (FLSA) for a majority of State employees. In determining eligibility for overtime, the designation of the Work Week Group (WWG) is the State's method of recognizing whether a class is covered by FLSA or is exempt from FLSA. For the Department of General Services, these WWG's are:

- **WWG 2**: Employees in classifications assigned to WWG 2 are covered by FLSA and eligible for overtime compensation.
- **WWG E and SE**: Employees in classifications assigned to WWG E or SE are exempt from FLSA provisions and are not eligible for overtime compensation.

To determine an employee's work week group, refer to the employee's classification title in the Civil Service Pay Scales which can be found on the California Department of Human Resources (CalHR) website: http://www.calhr.ca.gov/state-hr-professionals/Pages/pay-scales.aspx (Section 15, Salaries of Civil Service Classifications, Alphabetic Listing).

### Work Week Group E and SE Employees

**WWG E/SE** employees are paid on a 'salaried' basis with an average work week of 40 hours. The department policy for WWG E/SE employees is to report actual time expended by project. PAL hours entered in excess of a 40 hour workweek will not initiate an overtime payment.

Employees in Work Week Group (WWG) E and SE are exempt from coverage under the Fair Labor Standards Act (FLSA) which means they are considered 'salaried' employees and are *not eligible* for overtime payment.

Consistent with the 'salaried' nature of a position, an FLSA exempt employee:

1. Shall not be charged any paid leave for absences in less than whole day increments.
2. Shall not be docked pay for absences of less than a whole day.
3. Shall not be subject to a disciplinary action suspension in less than full week increments unless there is a violation of a major safety rule; and
4. Shall not be required to document hours worked for payroll purposes.

For rank and file employees in WWG E/SE, the appropriate collective bargaining agreement has specific provisions that may address provisions not contained in the above definition.

# Attendance Reporting in PAL *Continue*

## Entering OT/CTO in PAL

As mentioned previously in this section, overtime is regulated by FLSA and is compensable to employees in WWG 2. However, the Bargaining Unit (BU) contains specific provisions on compensating overtime.

In most cases, overtime may be compensated on a cash or CTO basis for ordered overtime of at least 15 minutes. Full 15 minute credit is granted when half or more of the period is worked. Smaller fractional units will not be accumulated. Please refer to the employees BU to verify the proper application of overtime compensation for your employee.

When entering overtime/CTO in PAL, there is no applicable alias. The employee has worked and must post the time worked towards a specific Project and Task. To receive overtime/CTO in PAL, you will alter the Expenditure Type to:

- OTD – Over Time/Day (Cash compensation at time and one-half)
- OTS – OverTime/Day (Straight rate)
- CT07 – Time & Half (CTO compensation at time and one-half)
- CT06 – Straight Time

| Alias | Project | Task | Exp | Line Total | SUN Aug 06 | MON Aug 07 | TUE Aug 08 | WED Aug 09 | THU Aug 10 | FRI Aug 11 | SAT Aug 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1-SL | LEAVE | SL01 | STD -S | 0 | | | | | | | |
| 1-VAC | LEAVE | VA01 | STD -S | 0 | | | | | | | |
| ABMS D | 122844 | 26.02.01 | STD -S | 40 | | 8 | 8 | 8 | 8 | 8 | |
| ABMS | 122844 | 26.02.01 | OTD - | 8 | | | | | | | 8 |

| Alias | Project | Task | Exp | Line Total | SUN Aug 06 | MON Aug 07 | TUE Aug 08 | WED Aug 09 | THU Aug 10 | FRI Aug 11 | SAT Aug 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1-SL | LEAVE | SL01 | STD -S | 0 | | | | | | | |
| 1-VAC | LEAVE | VA01 | STD -S | 0 | | | | | | | |
| ABMS D | 122844 | 26.02.01 | STD -S | 40 | | 8 | 8 | 8 | 8 | 8 | |
| ABMS | 122844 | 26.02.01 | CT07 | 0 | | | | | | | 8 |

*Note:* PAL is case sensitive. Be sure to enter your information exactly as presented to you.

# Attendance Reporting in PAL *Continue*

## Entering OT/CTO in PAL Continue

### BPM Employees

BPM employees are required to report overtime to the following expenditures in order to bill vendors for the appropriate project cost. (See below)

| | |
|---|---|
| • OTDB-OvrTm/Day BPM | BPM OT Time & a Half Day Shift |
| • OTEB-OvrTm/Eve BPM | BPM OT Time & a Half Evening Shift |
| • OTNB-OvrTm/Nite BPM | BPM OT Time & a Half Night Shift |

### Casual Employees

Casual employees in the Direct Construction Unit (DCU) are required to use the following expenditures specific to DCU. These expenditures are used within PTU's Casual Attendance report and are necessary in order to key pay accurately. They are:

| | |
|---|---|
| • DTDD-DblTm/Day DCU | DCU OT Double Time – Day Shift |
| • DTED-DblTm/Eve DCU | DCU OT Double Time – Evening Shift |
| • DTND-DblTm/Nite DCU | DCU OT Double Time – Night Shift |
| • OTDD-OvrTm/Day DCU | DCU OT Time & a Half Day Shift |
| • OTED-OvrTm/Day DCU | DCU OT Time & a Half Evening Shift |
| • OTND-OvrTm/Day DCU | DCU OT Time & a Half Night Shift |

### Shift Differential Employees

Shift Differential is a supplemental pay for authorized employees working regularly scheduled evening and/or night shifts in classes designated in accordance with DPA/MOU provision.

All employees authorized to work an evening or night shift shall record their time using the appropriate shift expenditures in PAL. The PAL timesheet is the official timekeeping record and therefore, must include substantiation for shift payment by using PAL shift expenditures. Each expenditure for time worked has an Evening or Night version as shown in the examples below:

- STE – Str time/Eve (Regular Pay; Evening Shift)
- STN – Str time/Night (Regular Pay; Night Shift)
- OTE – Over Time/Eve (Overtime; Cash at time and one-half/Evening Shift )
- OTN – Over Time/Night (Overtime; Cash at time and one-half/Night Shift)

# Attendance Reporting in PAL *Continue*

### Shift Interface

The Shift interface is run four times each month. See the PAL Payroll calendar for the specific dates.

All interfaces are posted to the PAL Payroll calendar on the PAL website at:

http://inside.dgs.ca.gov/pal/Home/PayrollCalendar.aspx

The Shift interface is run at 8:00 a.m. on the interface days shown on the calendar. The interface extracts all approved PAL hours recorded to Shift expenditures for only those employees NOT on Locked In shift. The hours are then submitted to SCO via magnetic tape that is run in their system to generate pay.

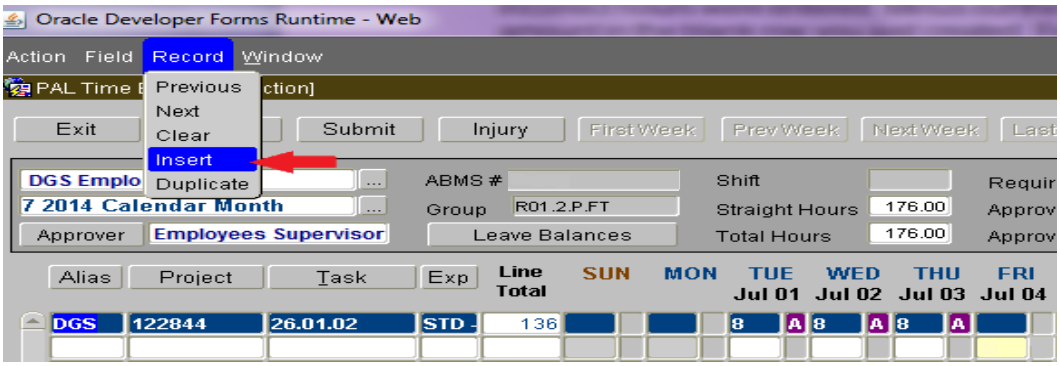
Employees on positive pay will receive a summarized (combined) warrant that includes both their regular pay and shift differential pay. Shift differential for monthly/negative pay employees is generated after their regular pay and will be received in a separate pay warrant (approximately 8 – 10 business days after they receive their regular pay).

Shift differential for employees on 'Locked In' shift, regardless of whether they are positive or negative pay, is not run through the shift interface as it is automatically generated with their regular pay.

### Correcting Time Entry

You cannot delete any record that has been Submitted or Approved, so to correct or remove an entry you must cancel-out the original, incorrect entry. This process can be done through time entry or pre-approve. The employee, the supervisor and/or the attendance has the ability to make these changes. Follow the steps below to make corrections:

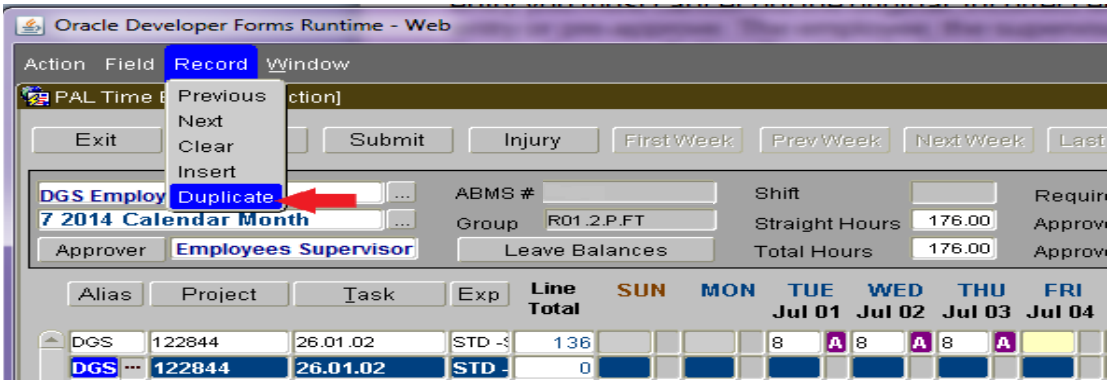
1. Position the cursor in the row of the project for which you plan to correct.
2. Insert a new record. Select '**Record**' from the menu bar and choose '**Insert**' from the drop down list. A blank row will appear on the timesheet directly below the incorrect entry.



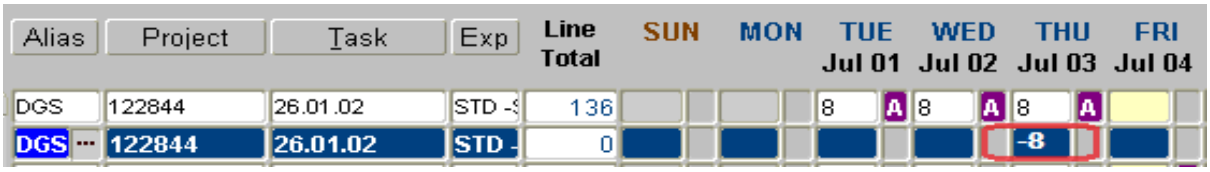
# Attendance Reporting in PAL *Continue*

**Correcting Time Entry** Continue

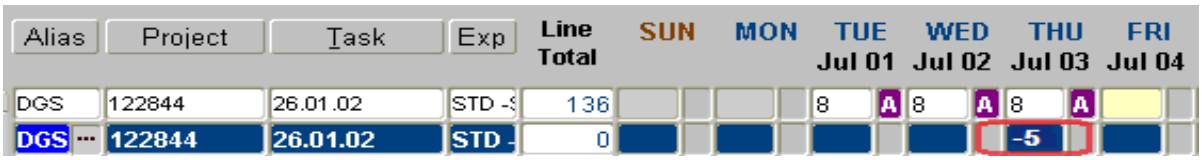
3. Go back to the menu bar and select '**Record**' and choose '**Duplicate**'. This will copy the incorrect records Alias, Project, Task and Expenditure Type from the row directly above.




4. **Remove the incorrect hours**. Position your cursor in the Hour's field on the day the incorrect hours were entered. Minus out the incorrect hours by entering a negative amount in the blank row you just created. For example, if the incorrect entry was for 8 hours, you need to enter –8 to cancel out the original entry.




5. **Correct the incorrect hours**. Position your cursor in the Hour's field on the day the incorrect hours were entered. Minus out the incorrect hours by entering a negative amount in the blank row you just created. For example, if the incorrect entry was for 8 hours and should have been 3, you need to enter –5.

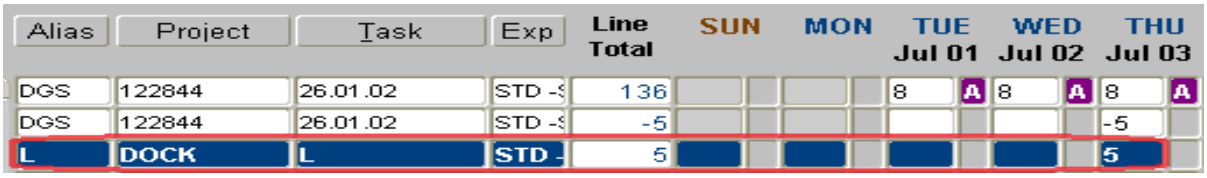


# Attendance Reporting in PAL *Continue*

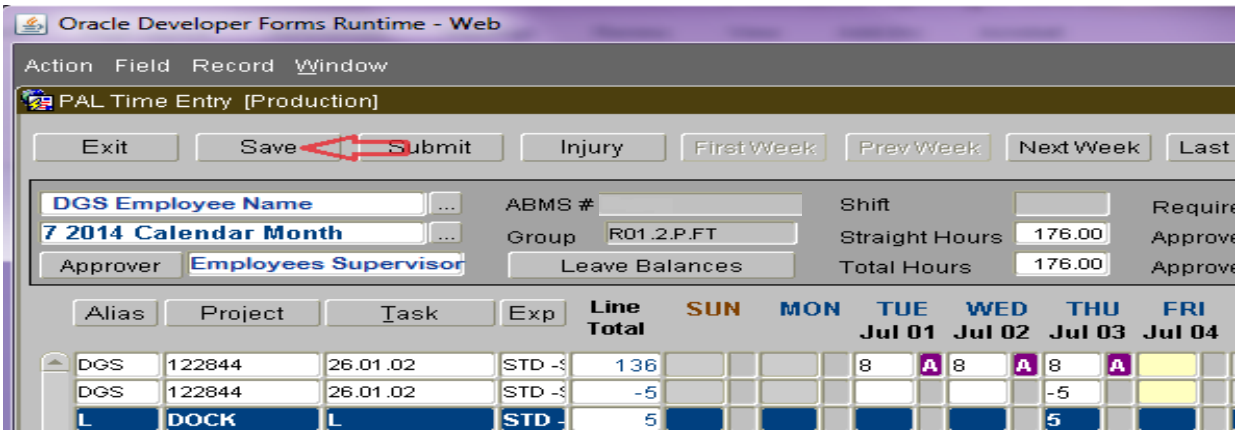
**Correcting Time Entry** Continue

6. **Correct the Project**. Create another new record to enter the correct project. Repeat steps 1-2 above to insert a new row. Choose the correct Alias from the list of values or manually enter the correct Project, Task and Expenditure Type. Enter the appropriate hours for the project. Refer to step 4 above to back out the incorrect hours posted to the incorrect project.

   ***Example**: Correction made for incorrect time posted of 8 hours on 7/03 - Employee worked 3 hours and was Dock 5 hours. (or if wrong number of hours was posted to the incorrect expenditure you would manually enter the correct Project, Task and Expenditure Type) in this case the EE was on Dock.*




7. When finished, press the SAVE button.



# Attendance Reporting in PAL *Continue*

**Corrections to Time Reporting & Projects in Project Accounting and Leave (PAL)**

Changes to time reporting in PAL can only be *made to the current pay period and one prior pay period.* Changes prior to that must be made by submitting a GS 22, PAL Time/Project Entry Form, to the Office of Human Resources (OHR) for processing. The GS 22 form is located on the OHR internet:

http://www.dgs.ca.gov/ohr/Resources/Forms.aspx

Employees whose leave is input by an Attendance Clerks should continue to use the Standard Form 634 (Std. 634) and/or timecard for reporting time and leave usage. If correction of a prior pay period is necessary, a corrected and approved Std. 634 and a GS 22 for PAL correction needs to be completed and submitted to OHR. All GS 22 forms for changes to time in PAL will be retained in the OHR.

**Changes to SRF & ARF Projects**

Requests for changes to Service Revolving Fund (SRF) and Architectural Revolving Fund (ARF) projects must be sent to the Office of Fiscal Services (OFS). ARF and SRF change requests must be submitted on separate GS 22 form, however, if your request is to transfer between ARF and SRF one GS 22 form is sufficient. All GS 22 forms for project changes will be retained in the OFS.

*NOTE:* Changes made to projects will not be updated in PAL.

# Attendance Reporting in PAL *Continue*

## Sample of PAL/Project Entry Form GS 22

DEPARTMENT OF GENERAL SERVICES

**PAL TIME/PROJECT ENTRY FORM**

GS-22 (Rev. 9/2012)

| 1. PAY PERIOD | | 2. POSITION NUMBER | 3. TIME BASE | 4. WWG | 5. CBID |
|---|---|---|---|---|---|
| MONTH | YEAR | | | | |

| 6. EMPLOYEE NAME (Last, First MI) | 7. ABMS# | 8. OFFICE/BRANCH |
|---|---|---|
| | | |

| 9. FROM | | | | 10. TO | | | | 11. | SUN | MON | TUE | WED | THU | FRI | SAT | TOTAL | 12. BILL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Alias | Project# | Task# | Exp Type | Alias | Project# | Task# | Exp Type | DATES: | | | | | | | | HOURS | RATE ($) |
| | | | | | | | | HRS: | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| | | | | | | | TOTAL HOUR REPORTED: | | | | | | | | | | |

13. REASON FOR TRANSFER OF HOURS, CHANGE IN LEAVE OR EXPENDITURE:

| CERTIFICATION BY EMPLOYEE: *To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.* | | CERTIFICATION BY SUPERVISOR: *To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.* | |
|---|---|---|---|
| 14. EMPLOYEE'S SIGNATURE | DATE | 15. SUPERVISOR'S SIGNATURE | DATE |

INSTRUCTIONS

If completing on-line, start at the Pay Period and tab after each field.

| | | | |
|---|---|---|---|
| 1. PAY PERIOD | Enter the 2-digit month and year. | 9. FROM | Enter the Alias or Project, Task & Expenditure currently on your timesheet. |
| 2. POSITION NUMBER | Enter the employee's 13-digit position number. | 10. TO | Enter the corrected Alias, Project Task & Expenditure. |
| 3. TIME BASE | Enter the employee's time base. If part time, enter fraction. | 11. DATES: | Enter dates under weekdays for week being corrected (i.e., 7/1 for July 1st). |
| 4. WWG | Enter the employee's WWG (i.e., 2, E, or SE). | 11. HRS: | Enter the hours expended to old/new project. |
| 5. CBID | Enter the employee's CBID (i.e., R01, S12, etc.) | 12. BILL RATE | Enter the bill rate for PAL hours transferred from or transferred out. |
| 6. EMPLOYEE NAME | Enter the employee's name. | 13. REASON | Enter the reason for the change. |
| 7. ABMS # | Enter the employee's ABMS number. | 12. CERT BY EE | Employee must sign and date the form acknowledging changes. |
| 8. OFFICE/BRANCH | Enter the Office or Branch name. | 13. CERT BY SUP | Supervisor must sign and date the form acknowledging changes. |

DEPARTMENT OF GENERAL SERVICES

**PAL TIME/PROJECT ENTRY FORM**

| INDIRECT OVERHEAD ACTIVITIES | PROJECT # | TASK# | EXPENDITURES TYPES | | | | | |
|---|---|---|---|---|---|---|---|---|
| HUMAN RESOURCES | INDIRECT | 1. | Expenditure Name | Straight | Premium | Expenditure Name | Straight | Premium |
| FINANCIAL RESOURCES | INDIRECT | 2. | Straight Time - Day | STD | | BPM OT - Day | | OTDB |
| BUSINESS SERVICES | INDIRECT | 3. | Straight Time - Eve | STE | | BPM OT - Eve | | OTEB |
| GENERAL ADMINISTRATIVE | INDIRECT | 4. | Straight Time - Night | STN | | BPM OT - Night | | OTNB |
| SECRETARIAL/CLERICAL | INDIRECT | 5. | CTO | CT06 | CT07 | | | |
| TRAINING | INDIRECT | 6. | Overtime - Day | OTS- Day | OTD | DCU OT - Day | | OTDD |
| INFORMATION TECHNOLOGY | INDIRECT | 7. | Overtime - Eve | OTS- Eve | OTE | DCU OT - Eve | | OTED |
| STATE EMPLOYEE'S CAMPAIGN | INDIRECT | 8. | Overtime - Night | OTS- Nite | OTN | DCU OT - Night | | OTND |
| STATEWIDE REALIGNMENT PROJECT | INDIRECT | 9. | Call Back - Day | CBOTD | CBOTSD | DCU Dbl Time - Day | | DTDD |
| BUDGET REALIGNMENT PROJECTS | INDIRECT | 10. | Call Back - Eve | CBOTE | CBOTSE | DCU Dbl Time - Eve | | DTED |
| GREENING DGS TEAM | INDIRECT | 11. | Call Back - Night | CBOTN | CBOTSN | DCU Dbl Time - Night | | DTND |
| EMERGENCY RESPONSE | INDIRECT | 12. | Standby OT | SBOT | | | | |
| BOND SUSPENSION | INDIRECT | 13. | Standby CTO | SBCTO | | Travel Time CTO | TT-CTO | |

DEPARTMENT OF GENERAL SERVICES
LEAVE CODES (ALIASES)

Please refer to the PAL Global Leave Alias List at:

http://pal.dgs.ca.gov/aliaslist/default

# Attendance Reporting in PAL *Continue*

## PAL POLICY; TIMELY ENTRY AND APPROVAL

Departmental policy requires monthly employees to enter and submit their PAL timesheet no later than the last day of the pay period. This occurs twice a month for Semi-monthly employees.

Supervisors are expected to approve submitted timesheets by the end of the next workday. Reporting dock requires additional approval as clarified in the Dock section of this manual.

***The Office of Human Resources (OHR) encourages offices/branches to establish internal policies that would require more frequent recording of time.***

### Untimely PAL

Untimely PAL approvals and inadequate timesheet reviews are causing the following adverse impacts:

- Inaccurate PAL leave balances
- Delays of overtime, shift and positive pay
- Re-work for supervisors, their staff and OHR
- Overpayment of pay creating an Accounts Receivable (AR) to the employee

Regularly scheduled interfaces extract approved PAL records. They are then submitted electronically to the State Controller's Office (SCO) to update leave balances and process overtime, shift and positive pay. When timesheets are not approved prior to interface dates, leave balances are not updated, and pay is not submitted for processing.

### Supervisor's Role

Managers and supervisors must ensure their staff's time is submitted timely, thoroughly and accurately. This includes confirming:

- Working projects are entered accurately
- Proper leave aliases are being used
- Proper expenditures are used for regular work and overtime
- Assuring the employee has sufficient leave available for the usage

For employees that have no computer access or are unavailable to complete their timesheet, PAL time can be entered by the office attendance Clerk or supervisors with enhanced PAL access.

# Attendance Reporting in PAL *Continue*

### Attendance Clerk Role

Attendance clerks should monitor their program's timesheets through the ABMS PAL Timesheet History screen and follow up with managers and supervisors until:

- all dock is entered and approved by the ABMS Dock Cutoff, and
- all timesheets are entered and approved at the end of the pay period.

The ABMS PAL Timesheet History screen is located on the ABMS Main Menu under the + View Lists menu item. Double click on + View Lists, and then select PAL Timesheet History.

Execute the report two days prior to each deadline (including dock cut-off) to inform Managers/Supervisors of all employees who have unapproved timesheets. Unapproved timesheets include the following PAL statuses: "W" – Working; "S" – Submitted; "R" – Rejected; and "M" – Missing. Continue to use the ABMS PAL Timesheet History screen until all of the timesheets within your office are approved.

### Detail Instruction for PAL Timesheets

Detailed instructions on the ABMS PAL Timesheet History screen can be found in the ABMS Attendance Clerk user guide on the ABMS website at http://inside.dgs.ca.gov/abms/UserGuides.aspx.

The PAL User Guide for Attendance Clerks can be found in the same location and includes instructions for completing the PAL timesheet, understanding PAL statuses, creating Personal Aliases and entering time for other employees.

### Absences during time of Approval

Supervisors with enhanced PAL access or attendance clerks can enter and submit time on behalf of absent employees at the close of the pay period.

Supervisors unavailable to approve time by the designated time frames should direct their employees to route their timesheet to another supervisor for approval. To do this, change the PAL Approver field to the available supervisor and press the Submit button.

# Attendance Reporting in PAL *Continue*

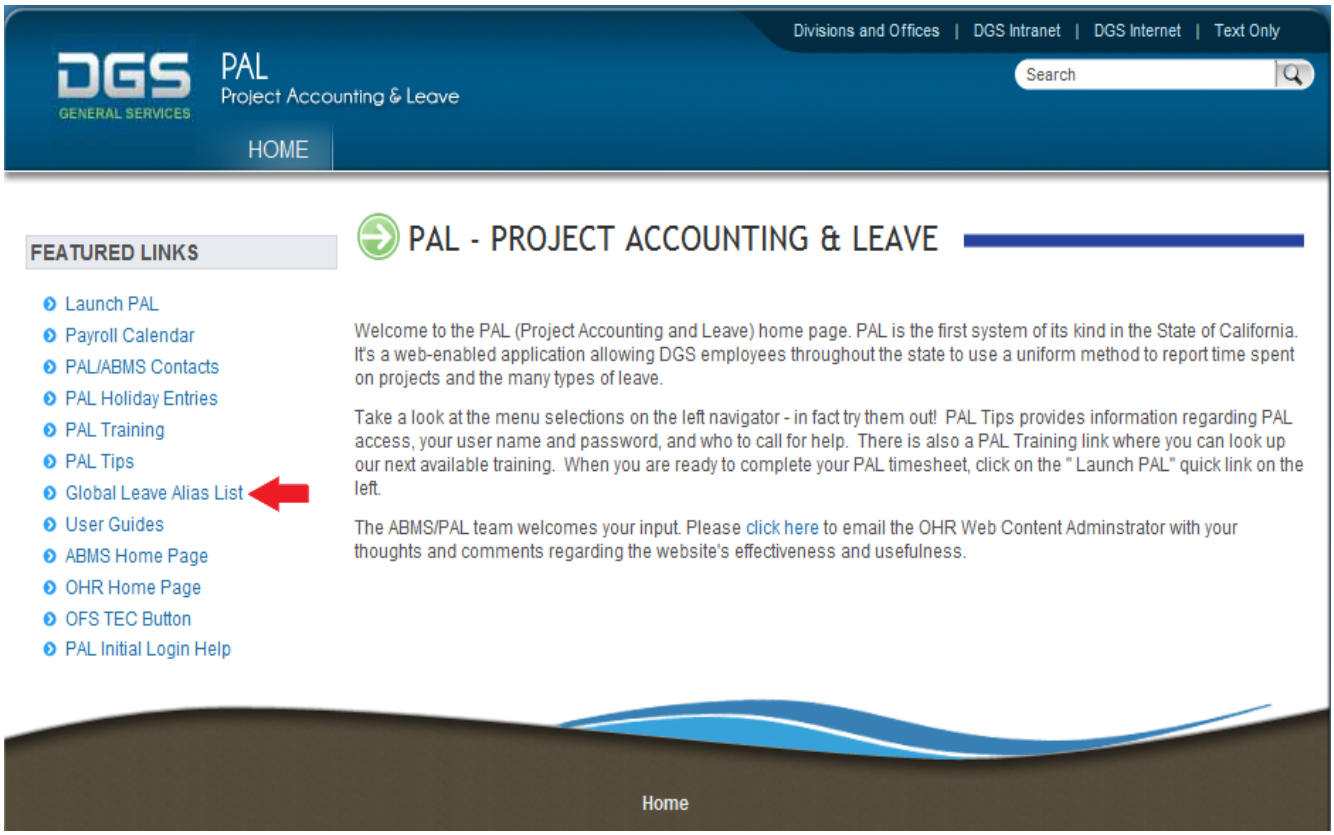
### Status

Statuses of time entry in PAL are as follows:

**WORKING (Green)** – supervisor cannot see a timesheet until it is in working status.
**SUBMITTED (Blue)** – employee has submitted their timesheet to the supervisor
**APPROVED (Purple)** – the supervisor has approved the employee's timesheet
**REJECTED (Red)** – the supervisor has rejected the timesheet back to the employee for corrections and/or adjustments.
**INTERFACED (Black)** – the timesheet was approved prior to the interface being processed. The leave entries will show an "**I**" next to the time posted.
**KEYED (Black)** – time appeared on the DGS PAL Not Interfaced to SCO report and was manually keyed by your assigned Personnel Specialist.

### Alias

List of Alias for recording entry into PAL are listed in the PAL User Guide:
http://inside.dgs.ca.gov/pal/Home.aspx



# Attendance Reporting in PAL *Continue*

### Example of Listing of Alias

| Alias Name | Project | Task | Expenditure | Description |
|---|---|---|---|---|
| ANNUAL LEAVE | | | | |
| AL | LEAVE | AL01 | STD -Str Time/Day | AL - USE |
| AL-BL | LEAVE | ALBL | STD -Str Time/Day | AL - USE- EXTENDED BEREAVEMENT LEAVE |
| AL-CAT | LEAVE | AL01 | STD -Str Time/Day | AL - IN LIEU OF CATASTROPHIC LEAVE |
| AL-FSP | LEAVE | AL70 | STD -Str Time/Day | AL - FAMILY SCHOOL PARTNERSHIP |
| AL-MU | LEAVE | AL81 | STD -Str Time/Day | AL - MENTOR USE |
| AL-P/NDI | DISABILITY LEAVE | AL01 | STD -Str Time/Day | AL - PENDING NDI |
| AL-P/NDI-CFRA | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - PENDING NDI-CFRA |
| AL-P/NDI-FMLA | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - PENDING NDI-FMLA |
| AL-P/SDI | DISABILITY LEAVE | AL01 | STD -Str Time/Day | AL - PENDING SDI |
| AL-P/SDI-CFRA | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - PENDING SDI-CFRA |
| AL-P/SDI-FMLA | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - PENDING SDI-FMLA |
| AL-P/WC-IDL | DISABILITY LEAVE | ALPI | STD -Str Time/Day | AL - PENDING WORKERS COMP-IDL |
| AL-P/WC-TD | DISABILITY LEAVE | ALPT | STD -Str Time/Day | AL - PENDING WORKERS COMP-TD |
| AL-S | LEAVE | AL04 | STD -Str Time/Day | AL - IN LIEU OF SICK |
| AL-S-CFRA | LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF SICK-CFRA |
| AL-S-CFRA-E/SE | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF SICK - CFRA; WWG E/SE |
| AL-S-FMLA | LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF SICK-FMLA |
| AL-S-FMLA-E/SE | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF SICK - FMLA; WWG E/SE |
| AL-SF | LEAVE | AL71 | STD -Str Time/Day | AL - IN LIEU OF FAMILY SICK |
| AL-SF (AB109) | LEAVE | AL72 | STD -Str Time/Day | AL - IN LIEU OF FAMILY SICK (Spouse/Parent/Child) |
| AL-SF-CFRA | LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF FAMILY SICK-CFRA |
| AL-SF-CFRA-E/SE | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF FAMILY SICK - CFRA; WWG E/SE |
| AL-SF-FMLA | LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF FAMILY SICK-FMLA |
| AL-SF-FMLA-E/SE | DISABILITY LEAVE | ALFM | STD -Str Time/Day | AL - IN LIEU OF FAMILY SICK - FMLA - WWG E/SE |
| AL-TE | LEAVE | ALIE | STD -Str Time/Day | AL - IN LIEU OF EXCESS HOURS |
| AL-TLD-RA | DISABILITY LEAVE | AL01 | STD -Str Time/Day | AL - WWG E/SE - TLD OR REASONABLE ACCOM |
| ATO - ADMINISTRATIVE TIME OFF | | | | |
| ATO-ELECT | LEAVE | AT01 | STD -Str Time/Day | ATO - ELECTION BOARD WORKERS |
| ATO-GOV-EMERG | LEAVE | AT01 | STD -Str Time/Day | ATO - GOVERNOR'S STATE OF EMERGENCY |
| ATO-OES | LEAVE | AT01 | STD -Str Time/Day | ATO - OES SEARCH AND RESCUE |
| ATO-OHR | LEAVE | AT01 | STD -Str Time/Day | ATO - (Use when authorized by OHR) |

### Alerts

Alerts are sent out when there are problems with a timesheet. The problem stated in the alert needs to be resolved in order for the alert to stop. The alert will continue to be sent out on a daily basis for three years or until the issue is resolved, whichever comes first.
Below are samples of alerts:

- Timesheet is submitted but not approved.
- Timesheet is in working status
- Please submit to your supervisor.
- Not enough hours for the pay period.
- The employee did not have a 40 hour week, not entitled to overtime.
- Timesheet is missing.
- When you receive any of the PAL alerts, please read carefully. The alert contains all pertinent information to assist you in researching the issue. The alert gives the employee's name, pay period in question, and the status of the timesheet. You should be able to resolve most alert issues by reading the alert. When you receive an alert, go to the timesheet in question and review it. You will probably see the problem and be able to answer your own questions or that of the employee and/or supervisor. If unable to resolve the issue, please contact your PTU specialist for assistance.

# Attendance Reporting in PAL *Continue*

**Absence and Additional Time Worked Report STD 634**

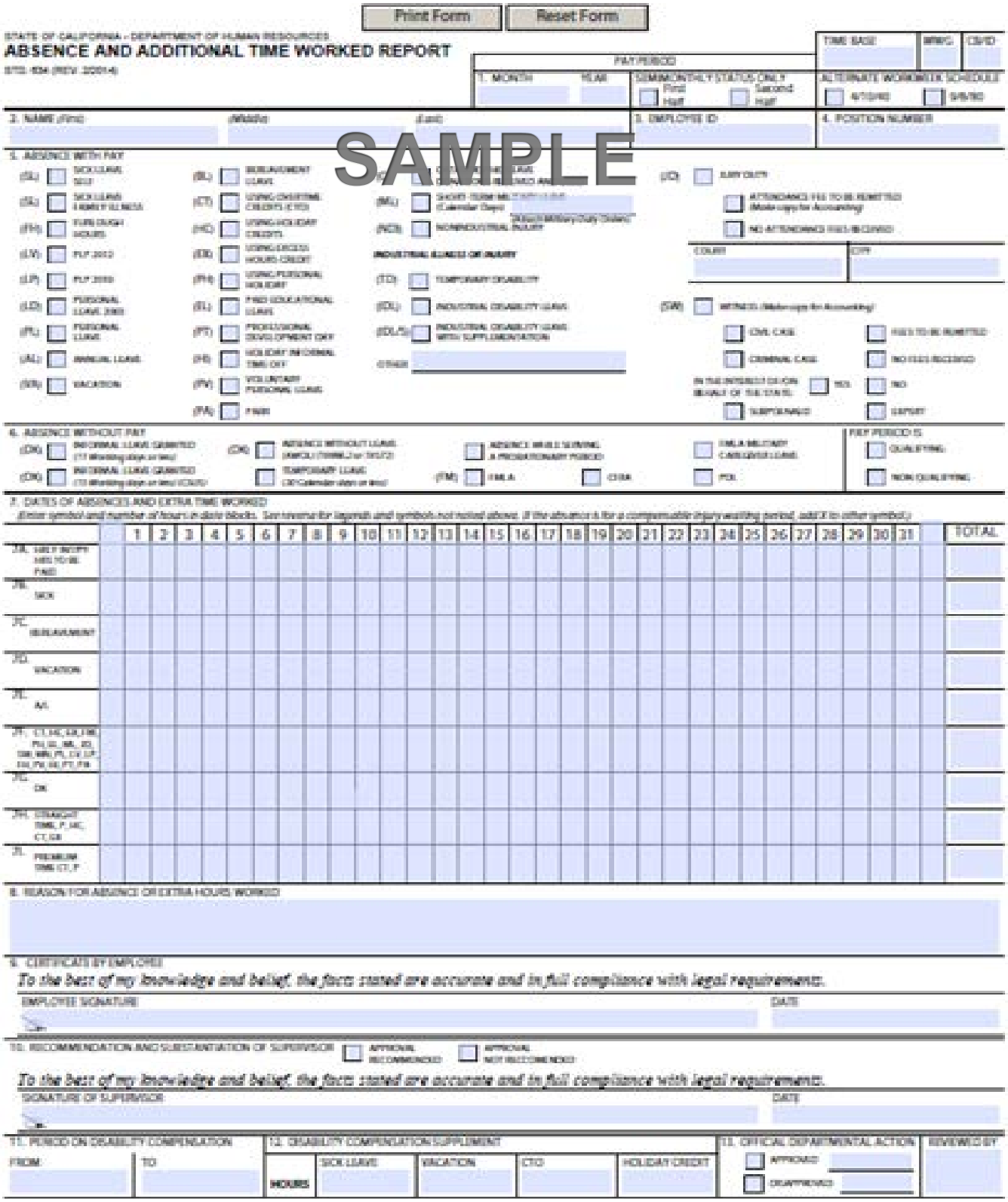
Employees whose agencies that does not have PAL access will utilize the Absence and Additional Time Worked Report (Std. 634) and/or timecard for reporting time and leave usage for each pay period.

Each 634 needs to be completed in ink as appropriate per the 634 instructions found on the back of the form. The employee will sign, date and submit back to his/her supervisor for review and approval. Provide a copy of the approved 634 to the employee and submit all original 634 to OHR the day after payday.

If correction of a prior pay period is necessary, a corrected and approved Std. 634 needs to be completed and “AMENDED” must be added to the top of the form and submitted to OHR. *(Signature of both the employee and supervisor is required)*

# Attendance Reporting in PAL *Continue*

## Sample of Absence and Additional Time Worked Report (STD 634) *Front*



Print Form | Reset Form

STATE OF CALIFORNIA - DEPARTMENT OF HUMAN RESOURCES

ABSENCE AND ADDITIONAL TIME WORKED REPORT

STD. 634 (REV. 2001-4)

SAMPLE

TIME BASE | WRKG | CB/ID

PAY PERIOD: 1. MONTH | YEAR

SEMI-MONTHLY STATUS ONLY: First Half | Second Half

ALTERNATE WORKWEEK SCHEDULE: 4/10 (040) | 9/80 (80)

2. NAME (First) (Middle) (Last) | 3. EMPLOYEE ID | 4. POSITION NUMBER

5. ABSENCE WITH PAY

(SL) SICK LEAVE (SU)
(SL) SICK LEAVE FAMILY ILLNESS
(FH) FURLOUGH HOURS
(LV) PLP 2012
(LP) PLP 2010
(LD) PERSONAL LEAVE 2003
(PL) PERSONAL LEAVE
(AL) ANNUAL LEAVE
(VA) VACATION

(BL) BEREAVEMENT LEAVE
(CT) USING OVERTIME CREDITS (CTO)
(HC) USING HOLIDAY CREDITS
(EX) USING EXCESS HOURS CREDIT
(PH) USING PERSONAL HOLIDAY
(EL) PAID EDUCATIONAL LEAVE
(PT) PROFESSIONAL DEVELOPMENT OFF
(HI) HOLIDAY INFORMAL TIME OFF
(PV) VOLUNTARY PERSONAL LEAVE
(PA) PAID

(ML) SHORT-TERM MILITARY LEAVE (Calendar Days)
(NCI) NONINDUSTRIAL INJURY

INDUSTRIAL ILLNESS OR INJURY
(TD) TEMPORARY DISABILITY
(DL) INDUSTRIAL DISABILITY LEAVE
(DL/S) INDUSTRIAL DISABILITY LEAVE WITH SUPPLEMENTATION
OTHER

(JD) JURY DUTY
ATTENDANCE FEE TO BE REMITTED (Make copy for Accounting)
NO ATTENDANCE FEES RECEIVED
COURT | CPP

(W) WITNESS (Make copy for Accounting)
CIVIL CASE | FEES TO BE REMITTED
CRIMINAL CASE | NO FEES RECEIVED
IN THE INTEREST OF/ON BEHALF OF THE STATE: YES | NO
SUBPOENAED | EXPERT

6. ABSENCE WITHOUT PAY
(DN) INFORMAL LEAVE SUBMITTED (11 Working days or less)
(DN) INFORMAL LEAVE SUBMITTED (10 Working days or less) (CNTS)
(ON) ABSENCE WITHOUT LEAVE (AWOL) (THREE or TRUE)
TEMPORARY LEAVE (30 Calendar days or less)
ABSENCE WHILE SERVING A PROBATIONARY PERIOD
(FM) FMLA | CFRA
FMLA MILITARY CAREGIVER LEAVE
PDL

PAY PERIOD IS: QUALIFYING | NON QUALIFYING

7. DATES OF ABSENCES AND EXTRA TIME WORKED
(Enter symbol and number of hours in date blocks. See reverse for legends and symbols not noted above. If the absence is for a compensable injury waiting period, add X to other symbol.)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7A. HRS P. NOPY HRS TO BE PAID | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7B. SICK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7C. BEREAVEMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7D. VACATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7E. AL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7F. CT, HC, EX, HI, PL, EL, ML, JD, SM, WN, PI, CV, CP, HA, PN, BL, PT, PA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7G. DK | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7H. OTHER OT TIME, P, HC, CT, EX | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7I. PREMIUM TIME CT, P | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

8. REASON FOR ABSENCE OR EXTRA HOURS WORKED

9. CERTIFICATE BY EMPLOYEE
*To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.*
EMPLOYEE SIGNATURE | DATE

10. RECOMMENDATION AND SUBSTANTIATION OF SUPERVISOR
APPROVAL RECOMMENDED | APPROVAL NOT RECOMMENDED
*To the best of my knowledge and belief, the facts stated are accurate and in full compliance with legal requirements.*
SIGNATURE OF SUPERVISOR | DATE

11. PERIOD ON DISABILITY COMPENSATION: FROM | TO

12. DISABILITY COMPENSATION SUPPLEMENT: HOURS | SICK LEAVE | VACATION | CTO | HOLIDAY CREDIT

13. OFFICIAL DEPARTMENTAL ACTION: APPROVED | DISAPPROVED

REVIEWED BY

# Attendance Reporting in PAL *Continue*

## Sample of Absence and Additional Time Worked Report (STD 634) *Back*

STATE OF CALIFORNIA - DEPARTMENT OF HUMAN RESOURCES

**ABSENCE AND ADDITIONAL TIME WORKED REPORT**

STD. 634 (REV. 2/2014)

**SAMPLE**

### INSTRUCTIONS

*WWG E and SE employees must contact their personnel offices for instructions*

**GENERAL INFORMATION**

1. All absences or additional hours worked by full-time or part-time employees should be reported on one form STD. 634 for each pay period. Report all time worked for permanent intermittent and part-time employees.
2. Prepare the number of copies required by your department. Employees who wish a copy for their own records, including supervisor's signature, may prepare an extra copy.

**INSTRUCTIONS FOR FILLING OUT FORM STD. 634 BY ITEM NUMBER** *(see reverse side)*

**1.** Enter pay period, month, and year, and complete other boxes as required by your department.

**2-4.** Complete name, employee identification (if applicable), and position number.

**5.** **Absences With Pay** - Check appropriate box, indicating type(s) of absence(s).

**6.** **Absences Without Pay (Dock)** - Complete all boxes, indicating type of unpaid absence and if the current pay period is qualified or nonqualified. Last box can be checked if employee is serving a probationary period to determine if employee will complete required number of working days.

*Qualifying Pay Period* - Eleven (11) or more paid days in a monthly pay period.

*Nonqualifying Pay Period* - Less than eleven (11) paid days in a monthly pay period.

***Note:*** *If the employee is absent without pay for more than eleven (11) consecutive working days, which fall between two (2) consecutive otherwise qualifying pay periods, one (1) pay period shall be disqualifying.*

**7.** Dates of Absences and Extra Hours Worked

**7a.** Enter time to be paid for each day, including paid absence hours for intermittent or part-time employees.

***Note:*** *Enter all hours to be paid in the total column.*

**7b.** **Sick and Sick Family** - Provisions on the usage of sick and family sick leave are outlined by the memorandum of understanding between your exclusive representatives and the State of California.

Indicate sick leave hours with a symbol "SL" on date of absence.

**7c.** **Bereavement Leave** - Provisions for bereavement leave are outlined by the memorandum of understanding between your exclusive representative and the State of California.

**7d.** **Vacation** - may be used in less than one (1) hour increments as outlined by the memorandum of understanding between your exclusive representative and the State of California and is shown on the appropriate date with the symbol "VA".

**7e.** **Annual Leave** - The "AL" symbol shall be used to indicate when annual leave credits have been used.

**7f.** Post proper symbol and number of hours for type of absence being reported.

MN - Mentoring Leave - eligible employees may receive up to 40 hours mentoring leave per calendar year once they have used an equal amount of their leave or personal time for this activity.

FM - Family and Medical Leave Act - under certain conditions, entitles employees up to 12 weeks of unpaid leave per year.

**Military Leave** - Attach a copy of any applicable military order. Every calendar day must be recorded, including any Saturday, Sunday, or holiday.

**Jury Duty or Witness** - An employee may be absent with pay for time actually served to perform jury duty, for time as a subpoenaed witness (other than a party to the suit), and for time as an expert witness testifying on behalf of the State. It is up to the employee to demand of the party requesting their appearance a subpoena and all allowable attendance and travel fees. The following absences are not compensable and the employee must charge leave or absence without pay: 1) subpoenaed witnesses who are a party to the suit, 2) subpoenaed witnesses not testifying on behalf of the State who elect to retain the attendance fees, 3) expert witnesses not testifying on behalf of the State, and 4) jurors who elect to retain the attendance fees. Subpoenaed witness fees for a civil trial are governed by Government Code (GC) Sections 68093-68097.10, fees for a criminal trial are governed by Penal Code Section 1329-29.1, and expert fees are governed by GC Section 68092.5. See SAM Sections 8594-94.3.

**7g.** Post proper symbol and number of hours for type of absence reporting.

Approved absence without pay -Approved dock
Absence without pay -AWOL

**An Unapproved Absence Without Pay** -- Can be any amount of time. If the absence exceeds five (5) consecutive working days, this constitutes an automatic resignation from State service pursuant to Government Code 19996.2 (without fault) or an adverse action can be taken under Government Code 19572 (with fault).

**7h.** Enter symbols and hours to be compensated at *straight* time as indicated below:

CT - Overtime worked for CTO

P - Overtime hours worked for pay

HC - Hours worked on a holiday

EX - Excess hours worked due to irregular work shift

**7i.** Enter symbols and hours to be compensated at *premium time* as indicated below (Personnel Office will convert to time and one-half (1-1/2)):

CT - Overtime worked for CTO

P - Overtime hours worked for pay

***Note:*** *Total column may be used for Items 7b through 7i.*

**8.** **Reason for Absence or Extra Hours Worked** - Examples include: Relationship information for sick leave absences (do not include a description of illness, condition, or diagnosis) or bereavement leave.

***Note:*** *This item also can be used for reporting reasons for overtime hours worked or for unpaid absences.*

**9.** **Employee's Responsibility and Signature** - Employees have the responsibility to give their supervisor advance notification when they anticipate a future absence. When an unanticipated emergency causes the absence, the employees are responsible for notifying their supervisor as soon as possible and keeping their supervisor informed as to the possible date of return. Employees are also responsible for promptly reviewing and signing their absence report at the end of the pay period and submitting to their supervisor.

**10.** **Recommendation of Supervisor's Responsibility** - Each supervisor is responsible for seeing that employees comply with the regulations governing absence from work. Supervisor is then responsible for promptly reviewing and signing the employee's absence report and forwarding it to the Personnel Office.

Before recommending approval for sick leave by an INTERMITTENT EMPLOYEE, supervisor shall certify that the employee was scheduled to work during the hours reported for sick leave.

***Note:*** *Methods of verification can include telephone or physician statement.*

**11-13.** Completed by Personnel Office only.

# Attendance Reporting in PAL *Continue*

### Dock

"Dock" (L) – defined as an informal leave of absence without pay; that is, **approved** time off by the supervisor. These absences must be inputted on PAL and submitted timely.

"Unapproved Dock" (D) – defined when in circumstance when Absence without Pay (AWOL) or "Approved Dock" (L) are inappropriate such as in case of an employee who is on attendance restriction.

"AWOL" (AWOL) – defined as informal leave of absence without pay that is **not approved** time off by the supervisor.

### Dock at Master Payroll Cutoff

If an employee is on dock at master payroll cutoff and the date of return is unknown, the employee should be shown on dock for the remainder of the pay period to avoid an overpayment situation. This will ensure the employee is paid on the regular pay date. If the employee returns to work before the end of the pay period and PAL has been approved the PS will requested additional pay and a supplemental warrant will be issued.

Supervisors must approve their employee's PAL timesheet weekly when reporting dock. All dock must be approved in PAL by 11:00AM on SCO Master Payroll Cutoff. Changes to dock after this time are considered "Late Dock" and must be communicated to your Personnel Specialist immediately to avoid overpayments.

### Dock Cutoff Dates

Dock cutoff dates can be found on the PAL Payroll Calendar located on the PAL intranet site. Please select the calendar for the current pay period and review it carefully for the SCO Master Payroll Cutoff date.

When reporting late dock for an employee, your assigned OHR Personnel Specialist must be notified immediately and is available to assist you. For employees in most Bargaining Units, late dock overpayments require returning the pay warrant to the Department of General Services' Office of Fiscal Services, canceling Direct Deposit if applicable, and issuing a salary advance within two to five business days after payday.

*Note:* Bargaining Unit 12 and 13 employees will receive their warrant as if the late dock had not occurred. However, the amount of the overpayment will automatically be deducted from the next applicable pay warrant.

Posting and approving all dock for the pay period by the cutoff dates and communicating changes immediately to your OHR Personnel Specialist are essential to ensure your employees are paid accurately and timely.

To identify your Personnel Specialist, use the following link PTU Roster Assignment Listing or contact our Customers Resource Unit (CRU) at (916) 376-5400.

# Attendance Reporting in PAL *Continue*

**Dock Cutoff Dates** Continue

If an employee is granted approved dock (L), then sick leave, vacation/annual leave, or any other paid leave credits CAN NOT BE USED TO BREAK the continuity of the docked during the employee's absences. Therefore, be aware when dock occurs on the last day of the pay period, credits posted to the first day of the following pay period CAN NOT be used to break the period of dock. The employee must PHYSICALLY return back to work in order to use available credits.

**REPORTING DOCK**

Employees can be docked in days, hours, or tenths. If the employee is to be docked for less than one hour, it must be reported in tenths. If the dock is 5 minutes or less, the employee cannot be charged dock (A, D or L), however, it is recommended that the employee make up the time during their lunch period (Refer to the bargaining contracts).

If the employee is to be docked between 6 minutes and 59 minutes, the chart listed below is to be used:

| MINUTES TO BE DOCKED | | | DECIMAL TO BE DOCKED |
|---|---|---|---|
| 0 | to | 5 | no dock |
| 6 | to | 11 | .1 |
| 12 | to | 17 | .2 |
| 18 | to | 23 | .3 |
| 24 | to | 29 | .4 |
| 30 | to | 35 | .5 |
| 36 | to | 41 | .6 |
| 42 | to | 47 | .7 |
| 48 | to | 53 | .8 |
| 54 | to | 59 | .9 |
| | | 60 | 1.0 hour |

For additional information refer to resources:

Bargaining Contracts

POM

PAL User Guide

## Attendance Reporting in PAL *Continue*

For most BU when reporting "Late Dock" the office is require to return the pay warrant to DGS Fiscal office. Below is the "Timely Payment of Wages" table for the listed BU, utilize the chart below to determine the number of salary advance the employees are entitled to and the number of days the salary advance is to be issued.

### Timely Payment of Wages

| BU | *LATE DOCK | *LATE DOCK SALARY ADVANCES PER CALENDAR YEAR | | ALL OTHER OVERPAYMENTS *(No fault of the employee)* Return warrant & issue salary advance within: |
|---|---|---|---|---|
| 1 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 4 | | 2 workdays after Pay Day |
| 2 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 2 | | 2 workdays after Pay Day |
| 4 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 4 | | 2 workdays after Pay Day |
| 9 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 2 | | 2 workdays after Pay Day |
| 10 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 2 | | 2 workdays after Pay Day |
| 11 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 4 | | 2 workdays after Pay Day |
| 12 | **Release** warrant, Accounts Receivable** payroll deduction from the first feasible pay period. | NA | | 3 workdays after Pay Day |
| 13 | **Release** warrant, Accounts Receivable** payroll deduction from the first feasible pay period. | NA | | 3 workdays after Pay Day |
| 14 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 4 | | 2 workdays after Pay Day |
| 15 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 4 | | 2 workdays after Pay Day |
| 19 | No applicable language. | | | |
| 21 | Return warrant & issue salary advance within 5 workdays after Pay Day. | 4 | | 2 workdays after Pay Day |

*Employees with an unpaid absence (dock or AWOL) after Master Payroll cutoff (See PAL Calendar).
**See applicable BU for Accounts Receivable terms.

*LEFT BLANK*

## Acronyms

Acronyms are words formed from initial letters of a name. For example, OHR is the acronym for "Office of Human Resources." Acronyms are used frequently in regards to personnel functions.

| | |
|---|---|
| ABMS | ACTIVITY BASED MANAGEMENT SYSTEM |
| AC | ATTENDANCE CLERK |
| ACA | AFFORDABLE CARE ACT |
| ADA | AMERICANS WITH DISABILITIES ACT |
| AR | ACCOUNTS RECEIVABLE |
| ATO | ADMINISTRATIVE TIME OFF |
| AWOL | ABSENCE WITHOUT LEAVE |
| AWWS | ALTERNATE WORK WEEK SCHEDULE |
| BCP | BUDGET CHANGE PROPOSAL |
| BOC | BOARD OF CONTROL |
| BPM | BUILDING & PROPERTY MANAGEMENT BRANCH |
| BSC | BUILDING STANDARDS COMMISSION |
| BSO | BUSINESS SERVICES OFFICE |
| BU | BARGAINING UNIT |
| CalHR | CALIFORNIA DEPARTMENT OF HUMAN RESOURCES |
| CALNET | CALIFORNIA INTEGRATED TELECOMMUNICATIONS NETWORK |
| CASE | CALIFORNIA ATTORNEYS IN STATE EMPLOYMENT<br>(BU 2) |
| CAT LEAVE | CATASTROPIC LEAVE POGRAM |
| CBID | COLLECTIVE BARGAINING IDENTIFIER DESIGNATION |
| CCF | CALIFORNIA CHILDREN & FAMILIES COMMISSION |
| CPA | CA. POWER AUTHORITY |
| CCR | CALIFORNIA CODE OF REGULATIONS or<br>CRITICAL CLASS REQUIREMENTS |
| CEA | CAREER EXECUTIVE APPOINTMENT |
| CERT | CERTIFICATION |
| CIU | CONSTRUCTIVE INTERVENTION UNIT |
| CLAS | CALIFORNIA LEAVE ACCOUNTING SYSTEM |
| COB | CLOSE OF BUSINESS |
| CRB | COLORADO RIVER BOARD |
| CRU | CUSTOMER RESOURCES UNIT |
| CSA | CAREER SUPERVISORY ASSIGNMENT |
| CSEA | CALIFORNIA STATE EMPLOYEE'S ASSOCIATION<br>(BU 1, 3, 4, 11, 14, 15, 17, 20, 21) |
| CSM | COMMISSION ON STATE MANDATES |
| CSP | CALIFORNIA STATE PAY SCALE |
| CSW | COMMISSION ON THE STATUS OF WOMEN |
| CTC | CALIFORNIA TAHOE CONSERVANCY or<br>CALIFORNIA TRANSPORTATION COMMISSION |

## Acronyms Continue

| | |
|---|---|
| C&P | CLASSIFICATION AND PAY |
| DFEH | DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING |
| DOD | DATE OF DISABILITY (WORKERS' COMP.) |
| DOF | DEPARTMENT OF FINANCE |
| DOI | DATE OF INJURY (WORKERS' COMP.) |
| DSA | DIVISION OF STATE ARCHITECT |
| DSQ | DUTY STATEMENT QUESTIONNAIRE |
| DTU | DISABILITY TRANSACTIONS UNIT(OHR-PTU) |
| EE | EMPLOYEE |
| EAP | EMPLOYEE ASSISTANCE PROGRAM |
| EAR | EMPLOYEE ACTION REQUEST |
| EFDS | ESSENTIAL FUNCTIONS DUTY STATEMENT |
| EEO | EQUAL EMPLOYMENT OPPORTUNITY |
| EMSA | EMERGENCY MEDICAL SERVICES AUTHORITY |
| EO | EXECUTIVE OFFICE |
| FLSA | FAIR LABOR STANDARDS ACT |
| FMLA | FAMILY MEDICAL LEAVE ACT |
| GC | GOVERNMENT CODE |
| GCC | GAMBLING CONTROL COMMISSION |
| GEN | GENERAL SALARY INCREASE |
| HAM | HIRING ABOVE MINIMUM |
| HQ | HEALTH QUESTIONNAIRE |
| IDL | INDUSTRIAL DISABILITY LEAVE |
| IDP | INDIVIDUAL DEVELOPMENT PLAN |
| IUOE | INTERNATIONAL UNION OF OPERATING ENGINEERS (BU 12, 13) |
| JOB | JOB OPPORTUNITY BULLETIN |
| LEAP | LIMITED EXAMINATION AND APPOINTMENT PROGRAM |
| LHC | LITTLE HOOVER COMMISSION |
| LOA | LEAVE OF ABSENCE |
| LRC | LAW REVISION COMMISSION |
| LR | LABOR RELATIONS |
| LRO | LABOR RELATIONS OFFICER |
| LT | LIMITED TERM |
| MCR | MODIFIED CLASS REVIEW |
| MIRS | MANAGEMENT INFORMATION RETRIEVAL SYSTEM |
| MOU | MEMORANDUM OF UNDERSTANDING |
| MQ | MINIMUM QUALIFICATIONS |
| MSA | MERIT SALARY ADJUSTMENT |
| NDI | NON-INDUSTRIAL DISABILITY INSURANCE |
| NOPA | NOTICE OF PERSONNEL ACTION |

## Acronyms Continue

| | |
|---|---|
| OAH | OFFICE OF ADMINISTRATIVE HEARNINGS |
| OAL | OFFICE OF ADMINISTRATIVE LAW |
| OAS | OFFICE OF AUDIT SERVICES |
| OBAS | OFFICE OF BUSINESS AND ACQUISITION SERVICES |
| OCC | OUT-OF-CLASS |
| OEM | OFFICE OF ENERGY MANAGEMENT |
| OFA | OFFICE OF FLEET ADMINISTRATION |
| OFS | OFFICE OF FISCAL SERVICES |
| OHR | OFFICE OF HUMAN RESOURCES |
| OL | OFFICE OF LEGISLATION |
| OLS | OFFICE OF LEGAL SERVICE |
| OPF | OFFICIAL PERSONNEL FILE |
| OPSC | OFFICE OF PUBLIC SCHOOL CONSTRUCTION |
| ORIM | OFFICE OF RISK & INSURANCE MANAGEMENT |
| OSP | OFFICE OF STATE PUBLISHING |
| OTR | OFFICE OF TECHNOLOGY RESOURCES |
| PA | PERSONNEL ANALYST |
| PAL | PROJECT ACCOUNTING AND LEAVE |
| PAM | PERSONNEL ACTION MANUAL |
| PAR | PERSONNEL ACTION REQUEST |
| PD | PROCUREMENT DIVISION or<br>PERMANENT DISABILITY (WORKERS' COMP.) |
| PNB | POST AND BID |
| PERB | PUBLIC EMPLOYMENT RELATIONS BOARD |
| PERS | PUBLIC EMPLOYEE' S RETIREMENT SYSTEM |
| PFT | PERMANENT/FULL TIME |
| PI | PERMANENT INTERMITTENT |
| P.I.E. | PERSONNEL INFORMATION EXCHANGE |
| PIMS | PERSONNEL INFORMATION MANAGEMENT SYSTEM |
| PIP | PROMOTION-IN-PLACE |
| PL | PERSONNEL LIAISION or<br>PAY LETTER |
| PLP | PERSONAL LEAVE PROGRAM |
| PMB | PROJECT MANAGEMENT BRANCH |
| PMPPM | PERSONNEL MANAGEMENT POLICY & PROCEDURES MANUAL |
| POM | PERSONNEL OPERATION MANUAL |
| PPM | PAYROLL PROCEDURES MANUAL |
| PS | PERSONNEL SPECIALIST |
| PTM | PERSONNEL TRANSACTIONS MANUAL |
| PTU | PERSONNEL TRANSACTIONS UNIT |

## Acronyms Continue

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|---|---|
| RA | REASONABLE ACCOMMODATION |
| RDO | REGULAR DAY OFF |
| RESD | REAL ESTATE SERVICES DIVISION |
| RPA | REQUEST FOR PERSONNEL ACTION |
| RTW | RETURN-TO-WORK |
| SAL | SALARY INCREASE |
| SAM | STATE ADMINISTRATIVE MANUAL |
| SCO | STATE CONTROLLER' S OFFICE |
| SDI | STATE DISABILITY INSURANCE |
| SILC | STATE INDEPENDENT LIVING COUNCIL |
| SISA | SPECIAL-IN-GRADE SALARY ADJUSTMENT |
| SMMC | SANTA MONICA MOUNTAINS CONSERVANCY |
| SPB | STATE PERSONNEL BOARD |
| SROA | STATE RESTRICTION OF APPOINTMENTS |
| SSA | SPECIAL SALAY ADJUSTMENT |
| SSC | SEISMIC SAFETY COMMISSION |
| TAU | TMPORARY AUTHORIZATION  APPOINTMENT |
| TEC | TRAVEL EXPENSE CLAIM |
| TLD | TEMPORARY LIMITED DUTY (WORKERS' COMP.) |
| TNA | TRAINING NEEDS ASSESSMENT |
| TOE | TRANSFER OF ELIGIBILITY |
| TP | TRAINING PLAN |
| T&D | TRAINING AND DEVELOPMENT ASSIGNMENT |
| WC | WORKERS' COMPENSATION |
| WWG | WORK WEEK GROUP |

## Reference

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|---|---|
| ABMS | http://inside.dgs.ca.gov/abms/Home.aspx |
| BAM | http://www.calhr.ca.gov/state-hr-professionals/Pages/benefits-administration-manual.aspx |
| Bargaining Contracts | http://www.calhr.ca.gov/state-hr-professionals/Pages/bargaining-contracts.aspx |
| CalHR | http://www.calhr.ca.gov/Pages/home.aspx |
| CalPERS | http://www.calpers.ca.gov/ |
| DGS Division & Office | http://inside.dgs.ca.gov/dgsnet/Home/OrgDirectory.aspx |
| EDD | http://edd.ca.gov/ |
| HR Forms | http://www.dgs.ca.gov/ohr/Resources/Forms.aspx |
| HR Memos | http://www.dgs.ca.gov/ohr/Resources/HRPolicyMemos.aspx |
| PAL | http://inside.dgs.ca.gov/pal/Home.aspx |
| POM | http://www.dgs.ca.gov/ohr/Resources/PersonnelOperationsManualPOM.aspx |
| Quick Links<br>AWWS Calendars<br>Bargaining Contracts<br>Bilingual Service Complaint Form<br>C&P Contact Listing<br>FMLA/SDI/NDI/WC Forms<br>PTU Assignment Listing<br>State Holidays<br>Zig New Hire Resources | http://www.dgs.ca.gov/ohr/Home.aspx |
| Savings Plus | https://www.savingsplusnow.com/ |
| SCO | http://www.sco.ca.gov/ |
| Social Security | http://socialsecurity.gov/ |
| Standard (STD) Forms | http://www.dgs.ca.gov/dgs/ProgramsServices/Forms/FMC/Search/pdf_fillPrint.aspx |
| Toolkits | http://www.dgs.ca.gov/ohr/Resources/Toolkits.aspx |