EMPLOYER: CSULB Research Foundation			GROUP NUMBER: AOA00003		
EMPLOYEE INFORMATION					
LAST NAME:		FIRST NAME:		MI:	
ID#/SSN:		SEX: MF			
DATE OF BIRTH (MM/DDYYYY):		DATE OF HIRE (MM/DD/YYYY):			
EMPLOYEE ADDRESS: Please check if this is a change in address					
STREET ADDRESS:					
CITY:		STATE:	STATE: ZIF		
E-MAIL ADDRESS:		FAX NUMBER:			
			WORK PHONE:		
ELECTION					
I ELECT THE FOLLOWING:	Amount	# of		Annual Election	
	<u> </u>	Pay Periods	Actual	Maximum	
Healthcare Account: Yes No	\$		\$	\$ 2,700 Plan Year	
Dependent Care Account    Yes    No	\$		\$	\$ 5,000 Calendar Year	
Pre-Tax Premium Deductions: health (6)-					