Cash Balance Benefit Program Election

CB 533 REV 10/19

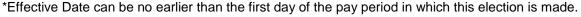[For CalSTRS' Official Use Only]

CALSTRS®

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COVERAGE ELECTION FOR A CASH BALANCE BENEFIT PROGRAM EMPLOYER AND/OR ACKNOWLEDGEMENT OF RECEIPT OF COVERAGE INFORMATION

Instructions: This form is used to make a coverage election for creditable service performed for a Cash Balance Benefit Program employer and/or to acknowledge receipt of information related to available coverage options.

Section 1: Employee Information

Provide either your Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

MAILING ADDRESS

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

HOME TELEPHONE

Section 2: Election (to be completed by employee)

Complete Section 2.1, 2.2 or 2.3 depending on which section applies to you. If you are unsure or need assistance completing one of these sections, please work with your employer.

Section 2.1 CalSTRS Defined Benefit Program MEMBER (check one):

☐ I decline Cash Balance Benefit Program coverage for eligible creditable service performed for this employer. I understand eligible service will default to Defined Benefit Program coverage.

☐ I elect Cash Balance Benefit Program coverage for eligible creditable service preformed for this employer. I understand my election is effective the first day of employment in the Cash Balance Benefit Program eligible position, or the date or effective date of my employer's action to provide the Cash Balance Benefit Program, whichever is later.

☐ I previously elected Cash Balance Benefit Program coverage for creditable service performed for this employer and now elect Defined Benefit Program coverage for creditable service performed for this employer as of: _____

EFFECTIVE DATE (MM/DD/YYYY)*

*Effective Date can be no earlier than the first day of the pay period in which this election is made.

Section 2.2 CalSTRS Defined Benefit Program NON-MEMBER (check one):

☐ I decline alternative retirement plan coverage for eligible creditable service performed for this employer, or no such coverage is offered by my employer. I understand eligible service will default to Cash Balance Benefit Program coverage.

☐ I elect alternative retirement plan coverage for eligible creditable service performed for this employer. I understand my election is effective the first day creditable service is performed in the eligible position or the date or effective date of my employer's action to provide the alternative retirement plan, whichever is later.

☐ I previously elected alternative retirement plan coverage for creditable service performed for this employer and now elect Cash Balance Benefit Program coverage for creditable service performed for this employer as of: _____

EFFECTIVE DATE (MM/DD/YYYY)*

Section 2.3 Trustee Service (form is only required to elect coverage):

☐ I elect Cash Balance Benefit Program coverage for trustee service performed for this employer as of: _____

EFFECTIVE DATE (MM/DD/YYY)*

*Effective Date can be no earlier than the first day of the pay period in which this election is made.

Section 3: Required Signature (to be completed by employee)

I certify that my employer provided me information about the available coverages for my creditable service and my rights and responsibilities.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYEE'S SIGNATURE	SIGNATURE DATE (MM/DD/YYYY)

Section 4: Employer Information and Certification (to be completed by employer)

I certify that the employee is eligible for the election and was provided required information about their coverage options.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYER OFFICIAL'S SIGNATURE	SIGNATURE DATE (MM/DD/YYYY)
EMPLOYER NAME Chabot-Las Positas Community College District	COUNTY AND DISTRICT CODE 01-065
EMPLOYER OFFICIAL'S NAME AND TITLE	