Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

MODIFIED BENEFIT OPTION ELECTION
Exempt

Election Type (select one for each):

New Enrollment ☐ Cancellation ☐ (If cancelling skip 1-2 below)

Must print in Black or Blue ink ONLY

Employee ID	Rcd No.	Last Name, First Name	Phone Number
Department	**Job Title**		**Effective Pay Period Begin Date**

By initialing below, I understand that I am agreeing to the following conditions:

1. By electing the MBO, I shall receive a differential in the amount of 4% above the base rate of pay and shall receive benefits as provided in the MBO section of the Compensation Ordinance. *Refer to the MBO section of the Compensation Ordinance for details regarding benefit and pay provisions.* _____ Initial Here

2. I understand that I have the option to enroll/dis-enroll in the MBO annually during Open Enrollment or if I experience a mid-year qualifying event. _____ Initial Here

ELECTION AGREEMENT	
By signing below I certify and affirm that I have read, understand, and agree to comply with the Modified Benefit Option (MBO) section of the Compensation Ordinance.	
Employee Signature (Print & Sign)	**Date**

This document/form incorporates use of e-signatures in accordance with the San Bernardino County Policy #03-12 and Standard Practice 1.

FOR PAYROLL SPECIALIST USE ONLY

The following information must be reviewed and verified prior to enrollment in or cancellation of the MBO:

Employee Status *(Select One)*: ☐ New Employee ☐ Open Enrollment ☐ Newly eligible or Ineligible

In addition to the required enrollment forms listed on the applicable payroll checklists, the following forms must be included in the MBO enrollment packet for new hire or if the employee is making changes in the County-sponsored medical plan, dental plan and/or vision plan:

☐ Medical Plan Enrollment/Change Form
☐ Medical Expense Reimbursement (FSA) Plan Enrollment Form
**During annual Open Enrollment period, employee can enroll and designate FSA amount in EMACS.*

☐ Dental Plan Enrollment/Change Form
☐ Vision Plan Enrollment/Change Form

Payroll Specialist (Print & Sign)	**Telephone**	**Date**

FOR HR USE ONLY			
Keyed By (Employee ID)	Date	Pay Period Effective	Effective Date