CSU Retiree Voluntary Vision Program Enrollment Form

Sign up for VSP® Vision Care. Choose the coverage that's best for you.

	Monthly
Retiree Only	$6.21
Retiree + One Dependent	$11.53
Retiree + Family	$12.37

Your VSP Coverage

Check one:

Retiree Only ❍
Retiree + One Dependent ❍
Retiree + Family ❍

Sign up for VSP.

Complete this form within 60 days of your retirement date

Enrolling in VSP is easy.

Within 60 days of your retirement date, please complete, sign, and mail this form to:

VSP Vision Care
Attn: Client Administrative Services, MS 229
PO Box 997100
Sacramento, CA 95899

Questions? Visit **vsp.com** or call VSP at **800.400.4569**.

Retireee Information

First Name ______________ Last Name ______________ SSN_____ - _____ - _____

Home Address ______________

City ______________ State ______________ Zip Code ______________

Billing Address (if different) ______________

City ______________ State ______________ Zip Code ______________

E-mail Address ______________ Phone ______________ Date of Birth ______________

Dependent SSN	Dependent Name (Only list dependents if you did not select "Retiree Only")	Date of Birth (Month/Day/Year)	Relationship to Employee (Spouse, Domestic Partner, Child, etc.)

Please read before signing. By signing below, I agree that all information is true and understand that I'm enrolling for a minimum 12-month period. The plan year runs January 1 through December 31 of each calendar year. If my effective date of coverage is February 1 or later, I am required to maintain enrollment for the balance of the plan year in which I enroll and for 12 months in the following plan year, unless a permitting event occurs that allows me to change my enrollment. Once I am enrolled for the required length of time as stated above, I understand my VSP plan will automatically renew unless I specifcally choose not to renew during the open enrollment period. I also acknowledge that enrollment in the plan authorizes CSU to deduct monthly vision premium from my CalPERS or CalSTRS retirement warrant. I understand that if my retirement warrant is not adequate to cover the cost of my monthly premium, VSP will bill me directly. I understand that failure to make premium payment by the required due date will result in the termination of my VSP plan benefit. As a CSU retiree, I also understand that I cannot enroll in both the CSU Retiree Voluntary Vision Plan and CSU COBRA vision at the same time.

Retirement Effective Date ______________

Employee Signature ______________ Date ______________

JOB #4985CM 04/11