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ELECTION OF CONTINUED VISION COVERAGE THROUGH COBRA

Questions? Call 1.800.400.4569

Group Name:	**Date of Qualifying Event:**	**Date COBRA Coverage Begins:**
CALIFORNIA STATE UNIVERSITY (CSU) RETIREE VOLUNTARY VISION PLAN		

ELECTING CONTINUATION OF VISION CARE COVERAGE:

Under COBRA, federal regulations specify that you and/or your dependent(s) have 60 days (the "Election Period") from the later of the date of continuation of coverage/COBRA notice, or the date of the loss of coverage to elect to continue participation, and 45 days from the date of election to submit the first payment to VSP.

DESCRIPTION OF QUALIFYING EVENT:

- ❑ Legal separation or divorce
- ❑ Dissolution of Registered Domestic Partnership
- ❑ Surviving Dependents / Widow
- ❑ Loss of child's dependent status

ELIGIBILITY PERIOD:

- ❑ 36-month coverage

COBRA APPLICANT INFORMATION:

Name of COBRA Applicant (Last, First, Middle Initial)	Social Security Number	Birth Date (Month/Day/Year)

Mailing Address (Number, Street, City, State, ZIP)

CURRENT/FORMER EMPLOYEE INFORMATION:

Name of Employee	Social Security Number of Employee	Relationship to Applicant

ELIGIBLE FAMILY MEMBERS (List dependents to be enrolled. Attach separate listing if more dependents exist.):

Name (Last, First, Middle Initial):	Social Security Number:	Birth Date (Month/Day/Year):	Gender:	Relationship to Employee:

MONTHLY CONTRIBUTION AMOUNT:

❑ One Party: $5.65	❑ Two Party: $10.50	❑ Three Party: $11.26

I elect to continue vision coverage at a rate of $___.___ per month. Rates and benefits are subject to change based upon the group's contract.

PAYMENT REQUIREMENTS:

All payments must be made directly to VSP. You will receive a coupon booklet for payments, which confirms your continued participation. The first payment submitted to VSP must be sufficient to bring payments current. Payments are due to VSP by the 1st of the month. There is a 30-day grace period. If VSP does not receive payment by the 30th of each month, your participation will end on the last day of the preceding month.

NOTIFICATION AGREEMENT and SIGNATURES (Parent or Legal Guardian must sign if dependents are minor children):

By signing below, I understand that should I become eligible under another group plan or Medicare, after electing COBRA continuation coverage, I will notify VSP in writing to terminate my vision care coverage.

Signature of COBRA Applicant:	Daytime Telephone Number ( )	Date:
Signature of Benefits Representative:	Campus:	Date:

RETURN COMPLETED FORM TO:
VSP/COBRA ADMINISTRATOR - P.O. BOX 997100
SACRAMENTO, CA 95899-7100