DIRECT PAYMENT AUTHORIZATION REQUEST FOR CONTINUED PREMIER VISION PLAN COVERAGE

Group Name: CALIFORNIA STATE UNIVERSITY 30077022 **Questions? Call 800.400.4569**

PART A – EMPLOYEE INFORMATION

Last Name_____ First Name_____ Middle Initial_____

Social Security Number_____ Date of Birth_____ Phone #_____

Street Address_____ City_____ ST_____ ZIP_____

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

Name (Last, First, Middle Initial)	Birth Date (MM/DD/YY)	Dependent SSN	Relationship to Employee

PART C – EMPLOYEE TO SIGN IF HE/SHE DOES NOT CHOOSE TO CONTINUE COVERAGE

I choose to discontinue my vision coverage while off pay status. I understand that my vision insurance coverage will lapse while off pay status effective on the first day of the second month following the pay period that the last vision deduction was taken on my pay warrant. For example, if the last deduction was taken in the May pay period, vision coverage will lapse as of July 1st.

EMPLOYEE'S SIGNATURE_____ DATE_____

PART D – EMPLOYEE TO SIGN IF HE/SHE CHOOSES TO CONTINUE COVERAGE

I choose to continue my vision plan coverage during the time I will be temporarily off pay status. I agree to make direct payments of the total premium to my vision plan carrier. I understand that failure to make timely premium payments and/or failure to notify the carrier of loss of eligibility during my leave status will result in termination of my coverage and the carrier's liability while off pay status. I understand that the carrier will not bill me, and I must pay the premium for the month in which I return to pay status.

I agree to pay a monthly rate of:

- ○ **Member Only $11.21**
- ○ **Member + One $22.42**
- ○ **Member + Family $36.09**

Return form to:

VSP - PO BOX 997100
Sacramento, CA 95899-7100
OR Fax to: 916.463.9031
OR Email to: CSUniv@vsp.com

Beginning with the following month/year:_____/_____* 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, my participation will end on the last day of the preceding month. I understand that, if I return to active service before completion of a paid quarter, refund will be made only for full months of overpayment. (Partial months cannot be refunded).

Employee's Signature:_____ Date: _____

**Rates and benefits are subject to change based on the group's contract.*

PART E – REASON FOR DIRECT PAY – TO BE COMPLETED BY BENEFITS REPRESENTATIVE

Type of absence: _____ Dates of absence: From_____ To_____

Last pay period premium deduction was made or will be made: _____
Month Date Year

Employee to pay for the months of_____ through_____

I certify that all the above information is correct according to our records:

Signature of Benefits Representative_____ Date_____

Campus_____ Phone Number _____