DIRECT PAYMENT AUTHORIZATION REQUEST FOR CONTINUED VISION PLAN COVERAGE

Group Name: CALIFORNIA STATE UNIVERSITY **Questions? Call 1-800-852-7600 ext. 4637**

PART A – EMPLOYEE INFORMATION

_____

Last Name First Name Middle Initial

Social Security Number _____ Date of birth _____

Street Address _____ City _____ ST_____ Zip _____

PART B – 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' SIGNATURE _____ DATE _____

PART C – 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:

VSP - P. O. BOX 997100
Sacramento, CA 95899-7105
ATTN: Mary Mitchell

A total of $ **9.13** per month is required, 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, your 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 D – 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 of the above information is correct according to our records:

Signature of Benefits Representative _____ Date _____

Campus _____ Phone Number _____