



VSP Enrollment Form for University of California Retirees

Complete, sign and date form and mail it to VSP's enrollment administrator.

Your enrollment form must be completed and postmarked no later than 31 days from your coverage effective date (see below). For questions about enrollment, call VSP at 800.400.4569 or visit vsp.com/go/UCretirees.

Retiree Information

First Name: _____ Middle Initial: _____ Last Name: _____

SSN: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address (if different): _____

City: _____ State: _____ Zip Code: _____

E-mail Address: _____

Phone: _____

Enrolling in VSP is easy.

Simply complete, sign, and date this enrollment form and mail it to: VSP Vision Care, Attn: Client Administrative Services MS 229, PO Box 997100, Sacramento, CA 95899-9986.

Your contribution amounts

	Monthly	Quarterly	Annual
• Retiree Only	\$11.88	\$35.64	\$142.56
• Retiree + One Adult	\$22.45	\$67.35	\$269.40
• Retiree + Child(ren)	\$22.66	\$67.98	\$271.92
• Retiree + Family	\$27.74	\$83.22	\$332.88

Your VSP Coverage

Choose one: Retiree Only Retiree + One Adult Retiree + Child(ren) Retiree + Family

Payment Options (choose one) Monthly payment option not available for credit card payments.

Credit Card Choose one: MC Visa Choose one: Quarterly Payments Annual Payment

Cardholder Name _____

Credit Card # _____ Expiration Date _____

Card Verification # _____ (3-digit number on back of MC, Visa)

Automatic Checking Withdrawal (If paying by automatic withdrawal, please include a voided check.)

Choose one: Monthly Payments Quarterly Payments Annual Payment

Bank Name _____ Account Holder Name _____

Checking Account # _____

Routing # _____ (9-digit number on bottom left side of check)

Check Payment is included (Please make check payable to VSP)

Choose one: Monthly Payments Quarterly Payments Annual Payment

Retiree: Insert an "X" in the box next to the family member(s) to be covered. The section below must be completed by your benefits representative or departmental representative.

Benefits representative or departmental representative: List all family members currently enrolled in UC-sponsored vision coverage and sign and date the form.

Family Member Name (Only list dependents if you selected "Retiree + One Adult," "Retiree + Child(ren)," or "Retiree + Family.")		Date of Birth (Month/Day/Year)	Relationship to Enrollee (Use codes listed below)
<input type="radio"/>			
<input type="radio"/>			
<input type="radio"/>			
<input type="radio"/>			

Legal spouse (S)

Same-sex domestic partner (D)

Opposite-sex domestic partner if one partner is over age 62 (L)

Child (natural, adopted, or overage disabled) (C)

Non-tax dependent child (natural or adopted) (T)

Non-tax dependent overage disabled child (N)

Partner's child/grandchild* (K)

Stepchild* (P)

Legal ward* (W)

Grandchild* (G)

*Must be a tax dependent

If you enroll, your coverage will begin on (coverage effective date) Month _____ Day _____ Year _____

Please read before signing. By signing below, I agree that all information is true and agree to the Participation Terms and Conditions listed on the back of this form. I understand that VSP will bill me directly. Failure to submit premium payment by the required due date will result in the termination of my VSP plan benefit. I also authorize VSP to debit my account in accordance with the above instructions.

Enrollee Signature _____ Date _____

Benefits Representative Signature	Benefits Representative Name	Phone ()	Campus Lab	Date
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Participation Terms and Conditions

Your Social Security Number will be requested only when needed by benefit plan administration for financial reporting or to verify your identity, in compliance with state and federal law.

As a participant in UC-sponsored plans, you agree to the following terms and conditions:

- 1.** You acknowledge and accept all terms and conditions of the UC-sponsored plans in which you are enrolled as stated in the plan booklets and UC's Group Insurance Regulations.
- 2.** If you enroll family members, the University and/or carrier may require proof of eligibility. Marriage or birth certificates, adoption papers, tax records, and the like may be requested. You agree to provide such documentation upon request.
- 3.** If you specifically ask UC representatives to intercede on your behalf with your insurance plan, University representatives will request minimum necessary health information required to assist you with your problem. If more protected health information is needed to solve your problem, in compliance with state privacy laws and federal laws, including HIPAA (Health Insurance and Portability and Accountability Act of 1996), you may be required to sign an authorization allowing UC to provide the insurance plan with relevant personal health information or authorize the insurance plan to release such information to the University representative.
- 4.** Your enrollment effective date is determined by your plan administrator unless otherwise stated.
- 5.** You certify that all enrolled family members are eligible for coverage based on the definitions and rules specified in the UC publications, Group Insurance Eligibility Factsheet for Employees and Eligible Family Members, and Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members. You agree that you will de-enroll them within 31 days if they lose eligibility. You further certify that all the information you provide is true to the best of your knowledge, under penalty of perjury.
- 6.** Making false statements about satisfying eligibility criteria, failing to notify the University of loss of eligibility within 31 days of such loss, or failing to provide documentation when requested will lead to de-enrollment of the family members and possible legal action. In addition, employees/retirees may be subject to disciplinary action (e.g., loss of health benefits for up to 12 months) and will be responsible for any employer contributions to and benefits paid by the plan for the ineligible coverage.