## DIRECT PAYMENT AUTHORIZATION REQUEST FOR CONTINUED PREMIER VISION PLAN COVERAGE



Group Name: CALIFORNIA STATE UNIVERSITY 30077022

| Street Address  | PART A – EMPLOYEE INFORMATION  |                              |   |                          |  |
|---|--|------------------------------|---|--------------------------|--|
| Social Security Number  |  |                              |   |                          |  |
| Street Address  | Last Name  | First NameI                  |   | Middle Initial           |  |
| 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/DDYY) 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 1s.  EMPLOYEE'S SIGNATURE DATE  PART D - EMPLOYEE TO SIGN IF HE/SHE CHOOSE 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  | Social Security Number   | Date of Birth                |   | Phone #                  |  |
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| 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   | PART D – EMPLOYEE TO SIGN IF HE/SHE CHOOSES TO CONTINUE COVERAGE   |                              |   |                          |  |
| O Member Only \$11.21 O Member + One \$22.42 O Member + Family \$36.09  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:  **Part E - REASON FOR DIRECT PAY - TO BE COMPLETED BY BENEFITS REPRESENTATIVE  Type of absence:  Dates of absence: FromTo   | 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   |                              |   |                          |  |
| 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:  *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  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  Date  Date  Date  Date  Date   | I agree to pay a monthly rate of: Return form to:  |                              |   |                          |  |
| 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:   |  | ○ Member + One \$22.42       | Sacramento, CA 95899-7<br>OR Fax to: 916.463.90 | 7100<br>31               |  |
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| Type of absence: Dates of absence: From To  | The same series are subject to change stated on the group's contract.  |                              |   |                          |  |
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| I certify that all the above information is correct according to our records:  Signature of Benefits Representative   | Last pay period premium deducti  | on was made or will be made: | Month Date Y                                    | <u></u>                  |  |
| Signature of Benefits RepresentativeDate  | Employee to pay for the months   | of t                         | hrough  |                          |  |
|   | I certify that all the above information is correct according to our records:  |                              |   |                          |  |
| Campus Phone Number   | Signature of Benefits Representa   | tive                         | Date  |                          |  |
|   | Campus   | Phone Number                 |   |                          |  |