

VSP VISION CARE ENROLLMENT FORM  
(NOT FOR OPEN ENROLLMENT USE)



# STATE OF CA RETIREE END OF COBRA ENROLLMENT FORM

Use this form to sign up for VSP® as a State of CA retiree once your COBRA coverage ends.

### ENROLLEE INFORMATION

COBRA End Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

SSN \_\_\_\_\_ Gender \_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Legal First Name \_\_\_\_\_

Legal Last Name \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Email Address \_\_\_\_\_

Phone Number \_\_\_\_\_

### YOUR VSP COVERAGE (CHOOSE ONE.)

**Maximum Age Limits:** Child Age: **26**. Dependent would be eligible until the last day of their birth month at the age listed above.

#### Basic Plan

- Retiree Only \$5.82 Monthly
- Retiree + One \$11.18 Monthly
- Retiree + Family \$12.03 Monthly

#### Premier Plan

- Retiree Only \$15.55 Monthly
- Retiree + One \$30.66 Monthly
- Retiree + Family \$33.34 Monthly

### ENROLLMENT

Up to 60 days after your COBRA coverage ends.

### VSP CLIENT NUMBER

Basic 30052010  
Premier 30058000

### QUESTIONS?

Call VSP at **800.400.4569** or visit [stateofcaretiree.vspforme.com](http://stateofcaretiree.vspforme.com)

## ENROLLING IN VSP IS EASY

Send this completed form to:  
VSP TPA Client Services MS 229  
PO BOX 997100  
Sacramento, CA 95899  
OR  
Fax to: **916.389.8304**  
Email to: [stateofca@vsp.com](mailto:stateofca@vsp.com)

ADD	FAMILY MEMBER NAME <small>(Only list dependents if you did not select Retiree only)</small>	DATE OF BIRTH <small>(Month/Day/Year)</small>	GENDER <small>(M/F)</small>	RELATIONSHIP TO MEMBER <small>(Month/Day/Year)</small>
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

**Please read before signing.** By accepting the enrollment terms, I agree that all information is true and accurate. I understand that I am enrolling in this voluntary plan as described in the benefit document for a minimum twelve (12) month period. I understand that upon completion of my twelve (12) months, I will not be eligible to make changes to my plan until the next open enrollment period. I understand my VSP plan will automatically renew unless I specifically elect not to renew. I understand that my VSP premiums will automatically be deducted from my retirement check. Uncollected premiums will result in the termination of my VSP benefit unless other payment arrangements are made with VSP.

Retiree Signature \_\_\_\_\_ Date \_\_\_\_\_

By signing above, I understand that I am enrolling for a minimum of a 12-month period.