VSP Vision Care Enrollment Form

State of California Retiree End of COBRA Enrollment Form

vsp vision care

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.

Basic Plan

☐ Retiree only	$6.11 Monthly
☐ Retiree + one	$11.74 Monthly
☐ Retiree + family	$12.63 Monthly

Premier Plan

☐ Retiree only	$16.33 Monthly
☐ Retiree + one	$32.19 Monthly
☐ Retiree + family	$35.01 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.**

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**

ADD	FAMILY MEMBER NAME (Only list dependents if you did not select Retiree only)	DATE OF BIRTH (Month/Day/Year)	GENDER (M/F)	RELATIONSHIP TO MEMBER (Spouse/Domestic Partner, Child, etc.)
☐				
☐				
☐				
☐				
☐				
☐				

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.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.