

# VSP® Vision Care Premier Enrollment Form

## The California State University

### Active



## Sign up for VSP Premier Benefits

### Enrollee Information

Full SSN \_\_\_\_\_ Official Campus Name \_\_\_\_\_

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

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

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

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

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

### Your VSP Premier Coverage (Choose one.)

- Employee Only . . . . . \$4.11 Monthly
- Employee + One . . . . . \$15.32 Monthly
- Employee + Family . . . . . \$28.99 Monthly

**Premier Dependent Requirement:** Eligible dependents not included with Premier enrollment will not be able to seek services under the Basic Plan.

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

Add	Family Member Name <small>(Only list dependents if you did not select Employee Only.)</small>	Date of Birth <small>(Month/Day/Year)</small>	Gender <small>(M/F)</small>	Relationship to Member <small>(Spouse/Domestic Partner, Child, etc.)</small>
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				

**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 enrollment in the Premier Plan is effective with the first Premier Plan deduction from my payroll check. Uncollected premiums will result in the termination of my VSP benefit unless other payment arrangements are made with VSP.

Enrollee Signature \_\_\_\_\_ Date \_\_\_\_\_

By signing above, I understand that I am enrolling in Premier for a minimum of a 12 month period and I certify that the family members listed are eligible dependents pursuant to CSU policy.

**Enrollment**  
Up to 60 days after your hire or new eligibility

**VSP Client Number**  
30077022

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

# ENROLLING

# IN VSP IS EASY

Send this completed form to:  
**VSP TPA Client Services**  
**P.O. BOX 997100**  
**Sacramento, CA 95899**  
**OR**  
**Fax to: 916.389.8305**  
**Email to: [CSUniv@vsp.com](mailto:CSUniv@vsp.com)**