VSP® Enrollment Form for University of California Retirees

Vision care for life

UNIVERSITY OF CALIFORNIA

Personal Information: Retiree/Survivor/Disabled Member

First Name..... MI ..... Last Name .....

SSN .....-.....-..... Date of Birth .....

Home Address .....

City ..... State ..... Zip Code .....

Billing Address (if different) .....

City ..... State ..... Zip Code .....

Email Address .....

Phone .....

Your VSP Coverage

(Check the box next to the coverage level and payment option you are selecting.)

	Monthly	Every 3 Months	Yearly
☐ Retiree/Surviving Spouse Only	☐ $12.84	☐ $38.52	☐ $154.08
☐ Retiree + Adult	☐ $24.27	☐ $72.81	☐ $291.24
☐ Retiree/Surviving Spouse + Child(ren)	☐ $24.49	☐ $73.47	☐ $293.88
☐ Retiree + Adult + Child(ren)	☐ $29.99	☐ $89.97	☐ $359.88

Enrolling in VSP is easy.

Mail: Simply complete, sign, date and mail this enrollment form to:

VSP Vision Care
PO BOX 997100, MS 315
Sacramento, CA 95899

Your enrollment form must be completed and postmarked no later than 31 days from your coverage effective date (see below).

Upon receipt of your form, VSP will bill you directly for your vision coverage based on the coverage level and payment option you selected.

For Surviving Spouse, your effective date will be the first of the month following date of death.

For questions about enrollment, call VSP at **866.240.8344**.

Survivor Only I am the survivor of: Retiree Name ..... Last 4 SSN .....
Please provide a copy of the retiree's death certificate.

Enrollee Information

(Check the box next to family member(s) to be covered.)

	Family Member Name	Date of Birth (Month/Day/Year)	Relationship to Retiree (Use codes listed below)
☐			
☐			
☐			
☐			

Legal spouse **(S)**, Same-sex domestic partner **(D)**, Opposite-sex domestic partner if over age 62 **(L)**, Child (natural or adopted) **(C)** Over-age disabled **(H)**, Non-tax dependent child (natural or adopted) **(T)**, Non-tax dependent over-age disabled child **(N)**, Partner's child/grandchild **(K)**, Stepchild **(P)**, Legal ward **(W)**, or Grandchild **(G)**

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 for my vision coverage. Based on the payment option I have selected, I authorize VSP to automatically debit my checking account or charge my credit card as directed. Automatic payments will be made only upon receipt of this enrollment form. If I selected to make check payments, failure to submit premium payments by the due date will result in the termination of my VSP plan benefit.

Enrollee Signature ..... Date .....

FOR CAMPUS/LAB/HR USE ONLY

List all family members currently enrolled in UC-sponsored vision coverage, including relationship code and date of birth in the Enrollee Information section.

Benefits Representative Signature	Benefits Representative Name	Phone	Location	Date

Effective Date of Coverage: Month..... Day..... Year.....

Rates effective 01/01/19

Participation Terms and Conditions

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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 disenroll 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 ineligible coverage.

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