

VSP Premier Enrollment/Qualifying Event (QE) Form



The California State University
Active

Enrollee Information

Hire/QE/FERP Date _____/_____/_____

FERP Yes No

Official Campus Name _____

SSN _____ Gender _____

Date of Birth _____/_____/_____

Legal First Name _____

Legal Last Name _____

Home Address _____

City _____ State _____ ZIP Code _____

Email Address _____

Phone Number _____

Premier Enrollment

Use this form to enroll in Premier or make changes within 60 days of your hire or qualifying event date.

VSP® Client Number

Active EE 30077022

FERP EE 30077315

Questions?

Call VSP at **800.400.4569** or visit csuactives.vspforme.com.

Enrolling in
VSP Is Easy

Send this completed form to your campus Benefit Officer.

Your VSP Premier Coverage (Choose One).

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.

- Employee Only \$4.03 Monthly
- Employee + One \$15.01 Monthly
- Employee + Family \$28.41 Monthly

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/N)</small>	RELATIONSHIP TO MEMBER <small>(Spouse/Domestic Partner, Child, Disabled Child, etc.)</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 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.

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.

©2023 Vision Service Plan. All rights reserved.

VSP is a registered trademark of Vision Service Plan. All other brands or marks are the property of their respective owners. 118801 VCCM

Classification: Restricted