

**VSP Enrollment/Qualifying Event Form**

The California State University  
Retirees



**Sign up for VSP®.**

**Enrollee Information**

Retirement/Qualifying Event 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. **Note:** Disabled children remain eligible beyond age 26.

**Basic Plan**

- Retiree Only \$5.10 Monthly
- Retiree + One \$9.31 Monthly
- Retiree + Family \$9.98 Monthly

**Premier Plan**

- Retiree Only \$14.80 Monthly
- Retiree + One \$27.63 Monthly
- Retiree + Family \$29.64 Monthly

**Enrollment**

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

**VSP Client Number**

Basic 30059425  
Premier 30078083

**Questions?**

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

**Enrolling in VSP Is Easy**

Send this completed form to:  
VSP Individual Billing  
MS 229  
PO BOX 997100  
Sacramento, CA 95899  
OR  
Fax to: **916.389.8305**  
Email to: **CSUniv@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/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 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](http://vsp.com).

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Classification: Restricted