Mail or Fax Completed Form to:
VSP–Attn: Client Administrative Services, MS 315
PO Box 997100
Sacramento, CA 95899-7100
Fax: 916.463.9031

Print Form
Reset Form

Premier Vision Plan Enrollment

California Department of Human Resources
State of California

A. Employee Information

Employee Name *(First, MI, Last)* | Social Security Number | Date of Birth

Mailing Address *(Number and Street)* | City | State | Zip Code

Type of Action: ☐ New Enrollment ☐ Change ☐ COBRA ☐ Cancel

E-mail Address | Telephone #

B. Enrollment Election

☐ I elect to enroll in a vision plan as shown above and authorize deduction to be made from my warrant by the State Controller (SCO) to cover my share of the cost of enrollment as it is now or may be in the future. Furthermore, the vision plan vendor is authorized to transmit, and SCO is authorized to accept enrollment data from the vision plan vendor. SCO shall consider my appearance on enrollment data in any form from the vision plan vendor as my authorization and agreement to initiate and make continuous deductions from my warrant for payment of premiums for a minimum 12 month period. I understand that depending on the enrollment date, my enrollment period may be greater than 12 months. You are eligible for vision benefits once each calendar year. If you elect the Premier Plan, you should consider waiting to utilize your annual benefit until the Premier Plan becomes effective. Please contact VSP should you have any questions.

☐ I do not wish to enroll into the Premier Vision Plan.

I have read and understand the general terms of enrollment. (See reverse side - page 2):

Employee's Signature | Date Signed

C. Dependent Information

Name	Relationship	SSN	Date of Birth	Add or Delete

If more dependents, attach additional pages; only eligible, authorized dependents may use the plan.

D. For Employing Agency Use Only

1. Deduction Code	2. Party Code	3. Premium Deduction	4. Effective Date of Enrollment	5. BU/CBID

6. Permitting Event Date	7. Permitting Event Code	8. Agency Name

9. Unit Code	10. Agency Code	11. Remarks	12. Agency Phone Number

11. I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment into the State Premier Vision Plan.

Name: _____ Signature: _____ Date: _____ Email: _____

California Department of Human Resources Privacy Notice on Information Collection

This notice is provided pursuant to the Information Practices Act of 1977.

The California Department of Human Resources (CalHR), Benefits Division, is requesting the information specified on this form CalHR 774 Premier Vision Plan Enrollment Authorization pursuant to the requirement set forth in California Code of Regulations Section 599.500(o).

The information collected will be used for verification of your relationship of the dependent child(ren), eligibility verification, payroll deduction, reporting to other state and federal agencies, coordination of benefits with other plans, solution of employee complaints, grievances, and appeal with the dental and/or vision plan and will be disclosed to the State Controller's Office, and federal agencies that may require this information.

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR and your employer will not be able to allow your PCR to be enrolled onto your dental and/or vision plan(s).

Department Privacy Policy
The information collected by CalHR is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please read our Privacy Policy located at: http://www.calhr.ca.gov/pages/privacy-policy.aspx.

Access to Your Information
The CalHR Privacy Officer is responsible for maintaining collected records. You have a right to access records containing your personal information we maintain. To request access, contact:
CalHR Privacy Officer
1515 S Street, 500N
Sacramento, CA 95811
916-324-0455
CalHRPrivacy@calhr.ca.gov

General Terms of Enrollment - Please read carefully:

Employees enrolling into this program will be restricted to maintaining enrollment for a minimum period of 12 months. Length of enrollment may be greater depending upon when you enroll into the plan. A plan year runs from January 1 of any year through December 31 of the same calendar year. Employees enrolling into this program will be restricted to maintaining their enrollment for the balance of the plan year in which they enroll and must maintain enrollment for 12 months in the following plan year unless a permitting event occurs to change their enrollment. Permitting event policy is established by the plan administrator, the California Department of Human Resources.

Only eligible dependents may be enrolled into this plan with the employee. Should you as the eligible employee enroll ineligible dependents, or otherwise maintain ineligible dependents on your plan, you may be held liable for the cost of any and all claims for services rendered. An ineligible dependent is any person you have enrolled onto your vision benefits plan or otherwise maintained on your vision benefits and is not considered an eligible dependent under the enrollment rules of the Department of Human Resources. Should you have questions related to enrollment under this program, you may contact the California Department of Human Resources at: (916)322-0300.