



I, _____, agree that I may be required to
(full name of employee)
 reimburse The California State University (CSU), my designated dental benefits plan, and/or my designated vision benefits plan for any expenditure made by the CSU, my designated dental benefits plan, and/or my designated vision plan for dental and/or vision claims, processing fees, administrative charges, costs, and attorney's fees incurred in conjunction with providing dental and/or vision coverage, under the standard eligibility rules of the Public Employees' Medical and Hospital Care Act (PEMHCA), to my domestic partner or any of his or her dependents if any of the submitted documentation is found to be incomplete, inaccurate, or fraudulent.

Full Name of Employee _____

SSN _____

Signature _____

Date _____

Full Name of Domestic Partner _____

Office Use Only

Campus

Campus Representative Signature

Date Received

cc: Employee
Personnel File

CSU -9/2001