The California State University
MISCELLANEOUS BENEFITS ENROLLMENT AUTHORIZATION FORM

Instructions:

Completion of this form enrolls or deletes coverage for employees under normal enrollment (at least half time for 6 months and 1 day) and part time Faculty and Coaches (qualified under AB 211 and CB Agreement) eligible for Vision, Life Insurance and Long-Term Disability benefits. Upon separation or loss of eligibility due to reduction of time base below 0.5 (for normal enrollments) or 0.4 (for AB 211 enrollments), deletion of coverage MUST be submitted immediately.

If the employee is ineligible for a particular benefit, place horizontal lines through the DED. CODE (Section 4) and ORG. CODE (Section 5). The effective date of enrollment is the pay period the employee is hired or becomes eligible (Section 7).

Please type or print clearly.

TO: STATE CONTROLLER – PPSD/PAYROLL SERVICES

(1) SOCIAL SECURITY	(2) NAME (FIRST) (MIDDLE) (LAST)	(3) POSITION NUMBER			
		AGENCY	UNIT	CLASS CODE	SERIAL

BENEFIT	(4) DED. CODE	(5) ORG. CODE	(6) CHANGE TYPE		(7) PAY PERIOD		(8) PARTY CODE
			NEW	DELETE	MONTH	YEAR	
VISION	450						3
LIFE INS.	250						
LTD	250						

Remarks:

(9) PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:		
FORM COMPLETED BY (PLEASE PRINT):	AUTHORIZED SIGNATURE:	
CAMPUS NAME	TELEPHONE NUMBER	DATE SIGNED
ENROLLEE CBID:		

Mail Completed Form To:

State Controller's Office
PPSD/Miscellaneous Deductions Unit
P.O. Box 942850
Sacramento, CA 94250

DISTRIBUTION: **ORIGINAL** - State Controller's Office **COPY** – Campus **COPY** - Employee

MISCBENEFITSENR (06/03)