



# 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							
<b>Remarks:</b>								
(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**