



The California State University

Miscellaneous Benefits Enrollment Authorization Form

Instructions:

Completion of this form enrolls or deletes coverage for employees appointed at least half-time for 6 months and 1 day, and part-time Lecturers and Coaches (qualified under AB 211 and CB Agreement) that are eligible for Vision, Life Insurance and/or Long-Term Disability (LTD) benefits. Upon separation or loss of eligibility due to reduction of time base below 0.5 (for general eligibility) or 0.4 (for AB 211) enrollments, deletion of coverage MUST be submitted to the State Controller's Office (SCO) immediately.

If enrolling the employee in a specific benefit, or if the employee is ineligible for a particular benefit, place horizontal lines through the Deduction Code (section 4) and Organization 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							
Please enroll or cancel coverage as indicated below:							
(1) Social Security Number	(2) Name (First) (Middle) (Last)			(3) Position Number			
	Agency	Unit	Class Code	Serial			
Employee CBID:							
BENEFIT PLAN	(4) Deduction Code	(5) Organization Code	(6) Change Type (Check One)		(7) Pay Period		(8) Party Code
			New Enrollment	Delete	Month	Year	
VISION All Employees exc. FERP (Monthly Deduction)	450	004	<input type="checkbox"/>	<input type="checkbox"/>			3
VISION FERP Employee Only (Annual Deduction)	450	996	<input type="checkbox"/>	<input type="checkbox"/>			
LIFE INSURANCE	250		<input type="checkbox"/>	<input type="checkbox"/>			
LTD	250		<input type="checkbox"/>	<input type="checkbox"/>			
REMARKS:							
PLEASE PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:							
FORM COMPLETED BY (PLEASE PRINT):				AUTHORIZED SIGNATURE			
CAMPUS NAME		TELEPHONE NUMBER			DATE SIGNED		

Mail Completed Form To:

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