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

<table>
<thead>
<tr>
<th>(1) SOCIAL SECURITY</th>
<th>(2) NAME (FIRST) (MIDDLE) (LAST)</th>
<th>(3) POSITION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AGENCY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>(4) DED. CODE</th>
<th>(5) ORG. CODE</th>
<th>(6) CHANGE TYPE</th>
<th>(7) PAY PERIOD</th>
<th>(8) PARTY CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>VISION</td>
<td>450</td>
<td></td>
<td></td>
<td>NEW, DELETE</td>
<td>MONTH, YEAR</td>
</tr>
<tr>
<td>LIFE INS.</td>
<td>250</td>
<td></td>
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<tr>
<td>LTD</td>
<td>250</td>
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</tr>
</tbody>
</table>

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

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