Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF PERSONNEL ADMINISTRATION

VISION PLAN ENROLLMENT AUTHORIZATION

STD. 700 (REV. 07/2020)

PLEASE TYPE OR PRINT CLEARLY USING A BALLPOINT PEN
SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE
SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

V

SECTION A

1. ENROLLEE'S SOCIAL SECURITY NUMBER

6. DATE OF BIRTH

2. MARITAL STATUS ☐ MARRIED ☐ DOMESTIC PARTNER ☐ SINGLE

3. GENDER ☐ MALE ☐ FEMALE ☐ NONBINARY

4. NAME *(First, Middle, Last)*

5. MAILING ADDRESS *(Number and Street, City, County, State, Zip)*

7. ACTION TYPE *(Check one)*

A. ☐ NEW--ENROLLING IN A PLAN FOR THE FIRST TIME *(Complete Sections A, B, and D)*

B. ☐ COBRA - ENROLLING IN COBRA CONTINUATION COVERAGE *(Complete Sections A, B, and D)*

C. ☐ CANCEL--CANCELLING COVERAGE FOR ALL ENROLLEES *(Complete Sections A, C, and D)*

8. SPOUSE'S OR DOMESTIC PARTNER'S NAME *(First, Middle, Last)*	9. SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER		10. DATE OF BIRTH
11. FAMILY MEMBER *(First, Middle, Last)*	12. RELATIONSHIP	13. SOCIAL SECURITY NUMBER	14. DATE OF BIRTH
15. FAMILY MEMBER *(First, Middle, Last)*	16. RELATIONSHIP	17. SOCIAL SECURITY NUMBER	18. DATE OF BIRTH
19. FAMILY MEMBER *(First, Middle, Last)*	20. RELATIONSHIP	21. SOCIAL SECURITY NUMBER	22. DATE OF BIRTH

SECTION B *(Do not complete this Section if the Cancel box in Section A is checked)*

1. NAME OF VISION PLAN BEING AUTHORIZED

2. PROVIDER/FACILITY NUMBER *(If applicable)*

SECTION C

1. NAME OF VISION PLAN BEING CANCELLED

SECTION D

1. CHECK APPROPRIATE BOX

A. ☐ I do not wish to enroll in a vision plan. *(Keep in employee's file)*

B. ☐ I elect to enroll in a vision plan as shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future. **I certify that I will only obtain vision services for myself and eligible dependents as defined by the State of California. Any unauthorized use of these services by ineligible persons is a misuse of State funds.**

C. ☐ I elect to cancel the vision plan shown above.

EMPLOYEE'S SIGNATURE *(See Privacy Notice on reverse of employee copy.)*

DATE SIGNED

SECTION E *(For agency use only)*

1. EMPLOYER DED. CODE	2. VISION PLAN CODE ORG. CODE	3. PARTY CODE	4. EMPLOYEE OR COBEN DEDUCTION AMOUNT	5. STATE SHARE AMOUNT	6. EFFECTIVE DATE OF ACTION	7. EMPLOYEE DESIGNATION	8. BARGAIN-ING UNIT
475		3	$	$			

9. TOTAL PREMIUM AMOUNT	10. PERMITTING EVENT DATE	11. PERMITTING EVENT CODE	12. AGENCY CODE	13. UNIT CODE	14. AGENCY NAME
$					

15. REMARKS

16. ☐ CHECK HERE IF PERMANENT INTERMITTENT EMPLOYEE

17. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State Vision Insurance Program.

18. TELEPHONE NUMBER *(Indicate if CALNET or give area code)*

19. DATE RECEIVED IN EMPLOYING OFFICE *(MO. DAY YR.)*

WHITE--TO CONTROLLER PINK--TO AGENCY GOLDENROD--TO EMPLOYEE

PRIVACY NOTICE

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the State Controller's Office and the vision insurance company for the purposes of identification and insurance coverage processing.

It is **mandatory** to furnish all information requested on this form except for employee's gender and marital status, which may be furnished on a voluntary basis and are used by the vision insurance company for statistical and actuarial purposes. Failure to provide the **mandatory** information may result in the vision insurance enrollment action not being processed or being processed incorrectly.

The State Controller's Office requires employee's social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151 and 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the vision insurance company providing coverage for the employee. Copies of the Vision Plan Enrollment Authorization are maintained in confidential files of the State Controller's Office for five years. Employees have the right of access to copies of their Vision Plan Enrollment Authorizations upon request. Send requests to: State Controller's Office, Personnel/Payroll Operations Bureau, P.O. Box 942850, Sacramento, California 94250-5878, Attention: Benefits Unit.