Clear Print

STATE OF CALIFORNIA — DEPARTMENT OF PERSONNEL ADMINISTRATION

VISION PLAN ENROLLMENT AUTHORIZATION

STD. 700 (REV. 4/2024)

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. FAMILY MEMBER *(First, Middle, Last)*	9. DEPENDENT TYPE	10. GENDER	11. SOCIAL SECURITY NUMBER	12. DATE OF BIRTH
13. FAMILY MEMBER *(First, Middle, Last)*	14. DEPENDENT TYPE	15. GENDER	16. SOCIAL SECURITY NUMBER	17. DATE OF BIRTH
18. FAMILY MEMBER *(First, Middle, Last)*	19. DEPENDENT TYPE	20. GENDER	21. SOCIAL SECURITY NUMBER	22. DATE OF BIRTH
23. FAMILY MEMBER *(First, Middle, Last)*	24. DEPENDENT TYPE	25. GENDER	26. SOCIAL SECURITY NUMBER	27. DATE OF BIRTH

Dependent Type: S - Spouse DP - Domestic Partner C - Child SC - Stepchild DPC - Domestic Partner Child PCR - Parent-child Relationship DC - Disabled Child

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
			$	$			

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

California Department of Human Resources Privacy Notice on Information Collection

The California Department of Human Resources (CalHR) is committed to the privacy of your personal information. We only collect information we need through lawful means to enable us to fullfill our mandated human resources obligations to the State of California civil service workforce.

All relevant information we collect is governed by the State of California Information Practices Act of 1977(Civil Code § 1798-1798.78), Government Code § 11015.5, Government code § 11019.9, and the California Public Records Act (Government Code Section 6250 et seq.).

Legal Authority for Collection and Use of Information

The California Department of Human Resources (CalHR), Benefits Division, is requesting the information specified on this form pursuant to the requirement set forth in California Code of Regulations Section 599.500(o).

The information collected will be used for verification of your relationship of the dependent child(ren), eligibility verification, payroll deduction, reporting to other state and federal agencies, coordination of benefits with other plans, solution of employee complaints, grievances, and appeal with the dental and/or vision plan(s).

Individuals should not provide personal information that is not requested or required.

The submission of all information requested is mandatory unless otherwise noted. If you fail to provide the information requested, CalHR and your employer will not be able to allow your dependents to be enrolled onto your dental and/or vision plan(s).

Disclosure and Sharing

CalHR does not, under any circumstance, sell your collected personal information. We also do not share your personal information with any organizations or individuals outside of CalHR.

However, we may share your personal information under the following circumstances:

1. To other state departments and third-party vendors for administering our human resource responsibilities as required by law.
2. You give us permission and we have your consent.
3. We may release information to a party with a legal authority such as a subpoena.

Privacy Policy

The information collected on this form is subject to the limitations in the Information Practices Act of 1977 and state policy. For more information on how we care for your personal information, please refer to to the State Controller's Office Privacy Policy, and Vision Service Plan's (VSP) Notice of Privacy Practices Policy.

Access to Your Information

You can review any personal information we collect about you. If you have any questions or concerns, please contact:

State Controller's Office
Personnel/Payroll Operations Bureau
Attention: Benefits Unit
P.O. Box 942850
Sacramento, California 94250-5878

VSP Contact:
Attention: Privacy Specialist
3333 Quality Drive
MS-163
Rancho Cordova CA 95670
916-858-7432