

October 1, 2008

**IMPORTANT NOTICE TO ALL BENEFIT ELIGIBLE EMPLOYEES REGARDING VISION DEPENDENT ENROLLMENTS**

To enhance benefits accessibility and provide improved customer service to employees, the Office of Human Resources-Benefits will begin collecting dependent information as a part of enrollment into the CSU Vision Plan (VSP). This new process of providing dependent information to VSP will expedite and streamline claims processing as well as ensure that dependents are covered by our vision provider on a timely basis. This will have no effect on our current vision plan coverage.

During the open enrollment period (September 15<sup>th</sup> - October 24<sup>th</sup>) employees are asked to review their enrolled dependent information for accuracy and eligibility. If we do not receive any information, vision plan dependents will default to reflect dependents currently enrolled in your dental plan. **There is no need to respond to this letter if the dependents enrolled in your dental plan will be identical to those enrolled in your vision plan.** However, if the dependents you wish to enroll in your vision plan differ from those on your dental plan, or you are not enrolled in dental benefits, you will need to complete the attached form. Please review the enrollment instructions chart below to determine action required. In the future, employees will also have the opportunity to update dependent information during any annual open enrollment period, or within 60 days of a qualifying family status event.

Please review the following chart to determine if there is any action required on your part.

<b>DESIGNATION CHART FOR DEPENDENT VISION ENROLLMENT PROCESS</b>	
YOU ARE ENROLLED IN DENTAL	<b><u>If your dependent information is accurate, there is no action necessary on your part.</u></b> The dependents on your dental enrollment will be included on your vision program.
YOU ARE NOT ENROLLED IN DENTAL	Complete the vision dependent enrollment worksheet and return it to the Benefits Office no later than October 24, 2008.
YOU ARE ENROLLED IN HEALTH ONLY	Complete the vision dependent enrollment worksheet and return it to the Benefits Office no later than October 24, 2008.
YOU ARE ENROLLED IN FLEXCASH /HEALTH <b>(Waived health and receive \$128 reimbursement)</b>	<b><u>If your dependent information is accurate, there is no action necessary on your part.</u></b> The dependents on your dental enrollment will be included on your vision program.
YOU ARE ENROLLED IN FLEXCASH/DENTAL <b>(Waived dental and receive \$12 reimbursement)</b>	Complete the vision dependent enrollment worksheet and return it to the Benefits Office no later than October 24, 2008.
YOU ARE NOT ENROLLED IN HEALTH/DENTAL OR FLEXCASH AND HAVE NO DEPENDENTS TO ENROLL.	<b><u>There is no action necessary on your part.</u></b> Your vision plan will include you only.
YOU ARE NOT ENROLLED IN HEALTH/DENTAL OR FLEXCASH AND HAVE ELIGIBLE DEPENDENTS TO ENROLL.	Complete the vision dependent enrollment worksheet and return it to the Benefits Office no later than October 24, 2008.

Please complete the attached form by providing the names of any additional eligible dependents that do not appear on your dental plan and return it to the Benefits Office in Sacramento Hall, Room 162. For questions or additional information contact Mary Ford, Benefits Manager, at 278-6213/86213.

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

**VISION INSURANCE – DEPENDENTS WORKSHEET**

You are eligible for vision insurance benefits for you and your eligible dependents in which the premium is fully paid by the CSU. You may cover dependents for vision insurance that are not enrolled on your health/dental plans provided they meet eligibility requirements. Before completing this worksheet please verify your dependent information on MySacState (Classic) at <https://my.csus.edu> MySacState Classic → Benefits Summary → Dental or Vision.

**Complete the following to update your vision enrollment.**

- Update my vision enrollment to include the dependents listed below. (You may be contacted to provide additional certification.)
- I have ineligible dependents/dependents I wish to remove from my health/dental enrollment. Please delete the individuals indicated below. (Further documentation may be required. You will be contacted by the Benefits Office if applicable.)

Action	Name	Relationship	Birthdate	SSN
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				
<input type="checkbox"/> Add <input type="checkbox"/> Delete				

**I understand that this enrollment must be received by the Benefits Office no later than October 24, 2008. I also certify under penalty of perjury that the information provided on this document is true and correct.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Telephone# / Date