

# VSDP LONG-TERM CARE PLAN AUTHORIZATION OF COVERAGE RETENTION

Complete this form to elect the continuation of your Long-Term Care coverage under the Virginia Sickness and Disability Program (VSDP) Long-Term Care Plan and to choose how you will pay for this coverage.

Send your completed form to: VSDP Long-Term Care Plan, P.O. Box 64011, St. Paul, MN 55164-0011.  
If you have any questions about completing this form, contact VSDP Long-Term Care Group at 800-761-4057.

## PART A. PARTICIPANT INFORMATION

<b>1. Name</b>	(First)	(MI)	(Last)	(Jr./Sr.)
<b>2. Address</b>	(Street)	(City)	(State)	(Zip+4)
<b>3. Date of Birth</b>	(mm/dd/yyyy)	<b>4. Daytime Phone</b>	<b>5. Home Phone</b>	

## PART B. PAYMENT OPTIONS

Select one payment option:

**Monthly Electronic Funds Transfer**

I authorize the Virginia Retirement System (VRS) or its designee and the financial institution named below to initiate monthly withdrawals from the account designated below for my continued coverage under the VSDP Long-Term Care Plan. This authority will remain in effect until I provide written cancellation to VRS or its designee and my financial institution.

I understand that if the electronic funds transfer rejects twice consecutively due to insufficient funds I will be directly billed on a quarterly basis.

Please deduct my monthly premium from the financial institution and account indicated below:

Financial Institution Name: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_

Choose one account:  Checking Account # \_\_\_\_\_ (Attach a **VOIDED** check only)

Savings Account # \_\_\_\_\_ (Attach a **VOIDED** deposit slip)  
and Bank Routing # \_\_\_\_\_

**Bill me directly on a quarterly basis** (4 times per year)

**Bill me directly semi-annually** (2 times per year)

**Bill me directly on an annual basis**

## PART C. PARTICIPANT CERTIFICATION

By signing this form, I elect continuation of coverage under the Virginia Sickness and Disability Long-Term Care Plan. I understand that I am responsible for paying the premium for the continued coverage and that failure to pay the premium will result in the lapse of my coverage.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

