



CONSENT TO PARTICIPATE IN AN INSURED VOLUNTARY PLAN
SCHEDULE OF INDIVIDUAL INFORMATION

My signature indicates my consent to participate in my employer's Voluntary Plan underwritten by an admitted disability insurer (shown below) pursuant to Section 3254(i)-2(e)(1) of Title 22, California Code of Regulations. This Voluntary Plan has been approved by the California Department of Insurance as a qualified alternative to the Unemployment Compensation Disability coverage currently provided through the California State Disability Insurance Program.

Employer Name: _____

Voluntary Plan Effective Date: _____

Voluntary Plan Insurer: _____ Policy Number: _____

I _____, understand that by consenting to participate in this plan, I will:
(Employee's Printed Name)

- Never be required to contribute more for the Voluntary Plan coverage than I would be required to contribute for the State Disability Insurance coverage.
- Always receive at least one greater right or benefit under the Voluntary Plan than I would receive under the State Disability Insurance Plan.
- Maintain my right to discontinue my participation in the future and return to the State Disability Insurance Plan.

Please complete all items below, sign, and date this form and return it to your Supervisor/Manager no later than _____.
(Date of Last Filing)

Each of the following items must be completed in order to determine whether your employer can secure the requisite percentage of employee consents and meet the Standards for Approval:

Social Security Number: _____ - _____ - _____

Gender: (please check one) Male Female Age: _____ years

Signature: _____ Date of Consent: _____