Clear Form

AUTHORIZATION OF COVERAGE RETENTION
LONG TERM CARE PLAN
VA SICKNESS AND DISABILITY PROGRAM AND VA LOCAL DISABILITY PROGRAM

Complete this form to elect the continuation of your Long Term Care coverage and to choose how you will pay for this coverage. Send your completed form to: Long Term Care Plan, PO Box 64011, St. Paul, MN 55164-0011 or fax the form to 952-833-5410. For questions about completing this form, contact illumifin Corp. at 800-761-4057.

PART A. PARTICIPANT INFORMATION

1. Name (First, Middle Initial, Last)		
2. Address (Street, City, State and ZIP+4)		
3. Long Term Care Provided Under: (Indicate the program you are covered under) ❑ Virginia Sickness and Disability Program (VSDP) (State employees only) ❑ Virginia Local Disability Program (VLDP)		
4. Date of Separation or End Date of VSDP/VLDP Claim	**5. Date of Birth** (mm/dd/yyyy)	**6. Phone Number**

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 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 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