Employment Development Department
State of California

Attachment C

VOLUNTARY PLAN EMPLOYER ADMINISTRATIVE CHANGES

If there are any changes to your company Voluntary Plan contact information, you must provide complete information about the changes within seven days.

Employer Name: _____ Voluntary Plan Number: _____

California Employer Account Number: _____

1. **Employer Primary Contact:**

   Name: _____ Title: _____

   Address: _____

   Phone: _____ Fax: _____

   Email Address: _____

2. **Employer Secondary Contact:**

   Name: _____ Title: _____

   Address: _____

   Phone: _____ Fax: _____

   Email Address: _____

3. **To be completed by and signed by the employer's authorized representative):**

   Print Name: _____ Title: _____

   Signature: _____ Date: _____

   Email Address: _____ Phone: _____

- **Complete and return this form by mail, email or the fax number below:**

Mailing Address:	Email Address and Fax:
EDD Disability Insurance Branch **Voluntary Plan Group** **PO Box 826880, MIC 29VP** **Sacramento, CA 94280-0001**	**VPProgram@edd.ca.gov** or Fax: **916-319-1438**

VOLUNTARY PLAN
EMPLOYER ADMINISTRATIVE CHANGES FORM
INSTRUCTIONS

1. Enter the full name of the Employer's Primary Contact, which is usually the owner, partner, or officer.

2. Enter the full name of the Employer's Secondary Contact, which is usually the benefits manager, human resources manager, or personnel manager to contact when the Employer Primary Contact is unavailable to deal with VP issues such as administration, securities, etc.

3. Enter the requested information for the person completing this form. This should be an authorized representative such as an owner, officer or partner.