Registration Form

ELECTIVE CALIFORNIA STATE DISABILITY

This form is for elective California State Disability Insurance coverage under California Unemployment Insurance Code Section 702.6(a)(b).

1. Please print clearly.
2. Send this form to Cast & Crew via:
   EMAIL EmployeeHelpDesk@castandcrew.com;
   FAX (818) 742-6568;
   DELIVERY 2300 Empire Avenue, 5th floor, Burbank, CA 91504
   ATTN: Data Operations
3. Please allow for 2 weeks processing time. Deduction is not eligible for retroactive calculations.

EMPLOYEE NAME	LAST FOUR DIGITS OF SSN	DATE OF BIRTH

EMPLOYEE ADDRESS

CITY

STATE	ZIP CODE	PHONE

E-MAIL ADDRESS

BY COMPLETING THIS FORM I HEREBY REQUEST THAT CALIFORNIA STATE DISABILITY INSURANCE PREMIUMS BE DEDUCTED FROM MY PAYCHECK WHILE WORKING OUTSIDE OF THE STATE OF CALIFORNIA. I, THE UNDERSIGNED, HEREBY ELECT AND MAKE APPLICATION TO HAVE THE SERVICES CONSIDERED AS EMPLOYMENT SUBJECT TO THE UNEMPLOYMENT INSURANCE CODE FOR DISABILITY INSURANCE ONLY. THE ELECTIVE AGREEMENT MAY BE TERMINATED AT ANY TIME BY FILING A REQUEST FOR TERMINATION..

EMPLOYEE SIGNAURE (Please sign, scan and return once completed)	DATE
X	