Adobe Systems, Inc.

California Voluntary Disability Plan

Opt In Form

My signature below indicates my choice to participate in the Adobe Systems, Inc. Voluntary Disability Plan, which is a State authorized replacement for participation in the California State Disability Insurance Plan (the "State Plan"), effective the next possible quarter following the receipt of the form.

Please enter the next possible effective date _____ of . (Please note that forms must be received at least 3 business days prior to the effective date.)

I understand that by making this election:

I will always receive the same or better benefits under the Adobe Voluntary Disability Plan than I would receive under the State Plan.

I will maintain my right to discontinue my participation in the Adobe Voluntary Disability Plan in the future and return to the State Plan coverage.

I further understand that should I discontinue my participation in the Adobe Systems, Inc. Voluntary Disability Plan at a later date, I may re-enroll in the Voluntary Disability Plan and my coverage will not commence until the first day of the calendar quarter following such election.

Name of Employee	Employee ID number
Signature of Employee	Date

Return your completed Enrollment Form to: *513-784-9734(Fax) or*

Submit by email