Adobe Inc.

California Voluntary Disability Plan

Opt Out Form

My signature below indicates my choice to reject participation in the Adobe Inc. Voluntary Disability Plan, which is a State authorized replacement for participation in the California State Disability Insurance 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 continue to participate in the California State Disability Insurance Plan as required by law.

I will continue to make SDI contributions at the rate established by law made through payroll deduction.

Should I elect to participate in the Adobe Inc. Voluntary Disability Insurance Plan at a later date, 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