California Voluntary Disability Insurance (VDI) 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 2024. (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

Upload your completed Enrollment Form to the Adobe Benefits Enrollment Site / My Profile / Employee File:

DSI/ADOBE VP June 2024