



CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community

520 E. Herndon Ave. • Fresno, CA 93720
(800) 288-9870 • FAX (559) 437-2965
www.cvtrust.org

GROUP MEMBERSHIP ENROLLMENT FORM

District Name
New Enrollment Effective Date: Date of Hire:
Open Enrollment
Address Change
Enrollment Change Qualifying Event:
Add/Remove Dep

EMPLOYEE INFORMATION

LAST NAME FIRST NAME MI MALE FEMALE
SOCIAL SECURITY NO. DATE OF BIRTH AGE HOME PHONE
MAILING ADDRESS CITY STATE ZIP
CLASS: CERTIFICATED CLASSIFIED TRUSTEE MANAGEMENT CONFIDENTIAL RETIREE

MARRIED DATE OF MARRIAGE: (REQUIRED)
DIVORCED SINGLE WIDOW / WIDOWER

DOMESTIC PARTNER REGISTRATION DATE

BENEFIT PLAN SECTION

PPO: PLAN Plan 1 Plan 2 Plan 3 Plan 4 Plan 5 Plan 6 Plan 7 Plan 8 Plan 9 Plan 10 HDHP1 HDHP2
RX: PLAN A B C D
HMO: PLAN KAISER* 1 2 3 4 5 6 7 (PLS CIRCLE ONE) PACIFICARE* LIFE* Additional Forms Required

DENTAL VISION EAP

DEPENDENT CODES

SP=SPOUSE CH=CHILD DD=DEPENDENT OF DOMESTIC PARTNER AD=ADOPTION*
DP=DOMESTIC PARTNER* SC=STEP CHILD LG=LEGAL GUARDIANSHIP*
Additional Forms Required

LIST ALL DEPENDENTS

Table with columns: DEP CODE*, LAST NAME, FIRST AND MIDDLE INITIAL, GENDER, SOCIAL SECURITY, DATE OF BIRTH, AGE, M D V (CIRCLE), ENROLL STATUS

REASON FOR DELETING DEPENDENTS: (REQUIRED)

IF A DEPENDENT IS DISABLED, PLEASE INDICATE NAME OF DEPENDENT HERE:

* ALL DEPENDENTS 19 YEARS OR OLDER MUST BE VERIFIED AS EITHER AN IRS DEPENDENT OR A FULL TIME STUDENT (12 UNITS OR MORE). ADDITIONAL FORMS AND/OR INFO REQUIRED FOR DOMESTIC PARTNERS, OVERAGE AND DISABLED DEPENDENTS, LEGAL GUARDIAN, ADOPTION, DIVORCE.

OTHER COVERAGE INFORMATION:

Including yourself, do any of the persons listed above have other coverage? YES NO

Table with columns: Name, Insurance Carrier, Policy Number, Effective Date

MEDICARE SECTION

PLEASE COMPLETE IF RETIRED

(COPY OF MEDICARE CARD REQUIRED)
ARE YOU RETIRED? YES NO
IF YES, DO YOU HAVE MEDICARE? YES NO
PART A. YES NO EFFECTIVE DATE
PART B. YES NO EFFECTIVE DATE

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE?
IF YES FOR YOUR DEPENDENTS:
PART A. YES NO EFFECTIVE DATE
PART B. YES NO EFFECTIVE DATE

AUTHORIZATION - PLEASE READ CAREFULLY

AUTHORIZATIONS - IF I HAVE CHOSEN A PREFERRED PROVIDER PLAN OR AN HMO PLAN I UNDERSTAND THAT I AM RESPONSIBLE FOR A GREATER PORTION OF MY MEDICAL COSTS WHEN I USE A NON-PARTICIPATING PROVIDER.
DEDUCTION AUTHORIZATION - IF APPLICABLE I AUTHORIZE MY EMPLOYER TO DEDUCT FROM MY WAGES THE REQUIRED CONTRIBUTIONS.
I HEREBY AUTHORIZE MY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY TO FURNISH AN AGENT, DESIGNEE, OR REPRESENTATIVE OF CALIFORNIA'S VALUED TRUST ANY AND ALL RECORDS PERTAINING TO MEDICAL HISTORY, SERVICES RENDERED, OR TREATMENT GIVEN TO ANYONE ENROLLED HEREUNDER OR ADDED HEREAFTER FOR PURPOSE OF REVIEW, INVESTIGATION, OR EVALUATION OF AN APPLICATION OR A CLAIM.
I ALSO AUTHORIZE CALIFORNIA'S VALUED TRUST OR ITS AGENTS, DESIGNEES, OR REPRESENTATIVES TO DISCLOSE TO A HOSPITAL OR HEALTH CARE SERVICE PLAN, SELF-INSURER, OR INSURER ANY SUCH MEDICAL INFORMATION OBTAINED IF SUCH DISCLOSURE IS NECESSARY TO ALLOW THE PROCESSING OF ANY CLAIM.
THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT AS LONG AS IT IS NECESSARY TO ENABLE CALIFORNIA'S VALUED TRUST TO PROCESS CLAIMS.
YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR FILES, IF REQUESTED.
I DECLARE, UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA, THAT THE FOREGOING IS TRUE AND CORRECT.

CVT USE ONLY

SIGNATURE DATE SIGNED