



CALIFORNIA'S VALUED TRUST

Healthcare Benefits for the Education Community
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www.cvtrust.org

GROUP MEMBERSHIP ENROLLMENT/CHANGE FORM

District Name: \_\_\_\_\_

New Enrollment

Date of Hire: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Change

Qualifying Event: Open Enrollment Add/Change Dependent(s) Address change Name Change

CVT USE ONLY - DATE COMPLETED

EMPLOYEE INFORMATION

Please print or type in black ink. See instructions on reverse.

Last Name First Name MI Male Female

Social Security No. Date of Birth Age

Home Phone Cell Phone Email Address

Mailing Address City State Zip

Married\* Date of Marriage (Required) Single Divorced Widow/Widower

Domestic Partner\* Date of Registration (Required)

Class: Certificated Classified Trustee Management Confidential Retiree

BENEFIT PLAN SECTION

PPO Plan: Plan 1-10 Rx Plan: A, B, C, D

Wellness PPO Plan HDHP 1 HDHP 2

Kaiser Plan\*: Plan 1-8 Wellness HMO Plan

Other Plans: Dental Vision Life\* EAP

DEPENDENT CODES

SP = Spouse\* CH = Child\* DD = Dependent of Domestic Partner\* AD = Adopted\*
DP = Domestic Partner\* SC = Stepchild\* LG = Legal Guardianship\*

LIST ALL DEPENDENTS

M = MEDICAL D = DENTAL V = VISION (CIRCLE)

Table with 8 columns: DEP CODE, LAST NAME, FIRST NAME, AND MIDDLE INITIAL, GENDER, SOCIAL SECURITY, DATE OF BIRTH, AGE, M D V, ENROLL STATUS

Reason for deleting dependents: \_\_\_\_\_ (Required)

If a dependent is disabled, please indicate name of dependent here: \_\_\_\_\_

\*Additional forms and/or information required for domestic partners, 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 4 columns: Name, Insurance Carrier, Policy Number, Effective Date

MEDICARE SECTION (PLEASE COMPLETE IF RETIRED)

Are you retired? Yes No If Yes, do you have Medicare? Yes No

Do any of your dependents have Medicare? Yes No A copy of retiree's/dependent's Medicare card is required. If not included, it will delay enrollment.

AUTHORIZATION - PLEASE READ CAREFULLY

Authorization: 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.
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 CVT 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 any application or a claim.
I also authorize CVT 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 is necessary to enable CVT to process claims.
Email Address: - The information you are asked to provide to CVT is used for technical and member administration only and is not shared with anyone outside the confines of your health coverage.
You are entitled to a copy of this signed authorization for your files, if requested.
I acknowledge that legal action to resolve any benefit dispute will be through arbitration.
I declare, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

CVT USE ONLY DATE RECEIVED

Signature Date Signed

\*Additional Forms Required