CVT HMO Membership Enrollment Form

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

District Name:

☐ New Enrollment - Effective Date:

☐ Qualifying Event - Effective Date:

Qualifying Event:
- ☐ Open Enrollment
- ☐ Address Change
- ☐ Name Change
- ☐ Add/Remove Dep

CVT USE ONLY

EMPLOYEE INFORMATION

NAME:______________________________ ☐ MALE ☐ FEMALE
(Last, First, Middle Initial)

SOCIAL SECURITY NO: ______________________ DATE OF BIRTH: ______________________ AGE: ____________

PRIMARY CARE PHYSICIAN:______________________ PCP#____________ GROUP #______________ EXISTING MEMBER? ☐Y ☐N

DEPENDENT CODES

SP=Spouse* DP=Domestic Partner*	CH=Child* SC=Step Child*	DD=Dependent of Domestic Partner* LG=Legal Guardianship*	AD=Adoption*

List Dependent(s) - Include Pertinent HMO Information

Dep Code*	Last Name, First name and Middle Initial / Primary Care Physician Name	PCP# / Medical Group #	Medical Group Name	EXISTING MEMBER?
SP DP	Last Name, First name and Middle Initial	PCP#	Medical Group Name	☐Y ☐N
	Primary Care Physician Name	Medical Group #		
SP DP	Last Name, First name and Middle Initial	PCP#	Medical Group Name	☐Y ☐N
	Primary Care Physician Name	Medical Group #		
SP DP	Last Name, First name and Middle Initial	PCP#	Medical Group Name	☐Y ☐N
	Primary Care Physician Name	Medical Group #		
SP DP	Last Name, First name and Middle Initial	PCP#	Medical Group Name	☐Y ☐N
	Primary Care Physician Name	Medical Group #		
SP DP	Last Name, First name and Middle Initial	PCP#	Medical Group Name	☐Y ☐N
	Primary Care Physician Name	Medical Group #		

* Additional forms and/or information required. If not included, it will delay enrollment.

Reason for Deleting Dependent(s):______________________________(Required)

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.

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 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 long as is necessary to enable CVT to process claims.

A Summary of Benefits and Coverage (SBC) summarizes important information about any health coverage option in a standard format and is available on the web at **www.cvtrust.org/sbc**. A paper copy is also available, free of charge, by calling **1.800.288.9870** (a toll free number).

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 declare, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

Signature ______________________________ Date Signed ______________________

*Additional Forms Required

ENROLLMENT / CHANGE FORM DIRECTIONS

FILL THE ATTACHED FORM OUT AS A NEW HIRE, DURING AN OPEN ENROLLMENT PERIOD, QUALIFYING EVENT CHANGES, OR PERSONAL INFORMATION CHANGES:

Always complete the Employee Information Section, Sign, and Date.

Please complete the following sections when applicable: Benefit Plan Section, List of Dependent(s), Other Coverage Information, Medicare Section.

Include any extra documentation as required, listed below.

NEW HIRES/MEMBERS:

Complete entire enrollment form, list all eligible dependents you wish to add, and include any extra documents as required.

OPEN ENROLLMENT, QUALIFYING EVENT CHANGES, OR PERSONAL INFORMATION CHANGES:

Plan Changes
Addition / Removal of dependent(s), (**Only** list the dependent(s) you are adding or removing, list reason for removal of dependent(s), and attach any required documentation.)
Personal Changes – (Name Change / Address Change)

ADDITIONAL FORMS REQUIRED*:

CVT HMO Enrollment Form, if enrolling in a CVT HMO plan **(CVT HMO plans not available for 65 and over members who are on Medicare.)**
Kaiser Enrollment Form, if enrolling in Kaiser
Life / Beneficiary Form, if enrolling in Life
CVT Domestic Partner Affidavit is required when:

- You are under 62 and partner is opposite sex
- You are over 62 and partner is opposite sex and not registered with the State of California as a Domestic Partner
- Same sex partners who are not registered as Domestic Partners with the State of California.

DOCUMENTATION THAT IS REQUIRED*. PLEASE ATTACH COPIES OF:

Marriage Certificate
Domestic Partner State Registration Certificate (Same sex partners or over 62 opposite sex partners)
Birth Certificate (for **ALL** dependent children)
Adoption – Adoption Placement Papers
Legal Guardianship - (Final court paperwork showing effective date)
Divorce Decree (Final court paperwork, showing final date of dissolution of marriage)
CVT Disabled Dependent Form
Medicare Card

* **ANY REQUIRED DOCUMENTATION THAT IS NOT INLCUDED WITH THE ENROLMENT FORM WILL DELAY THE ENROLLMENT PROCESS.**