GROUP MEMBERSHIP ENROLLMENT/CHANGE 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: ___/___/___
☐ Full Time ☐ Part Time

☐ **Enrollment Change Qualifying Event:** ☐ **Open Enrollment**
Effective Date: ___/___/___
☐ **Address Change**
☐ **Name Change**
☐ **Add/Remove Dep**
☐ **Retiree**

EMPLOYEE INFORMATION

Last Name _____ First Name _____ MI _____ ☐ Male ☐ Female

Social Security No. _____ Date of Birth _____ Age _____

☐ **Married** ☐ **Domestic Partner*** Date of Marriage _____ / Date of Registration _____ ☐ Single ☐ Divorced ☐ Widow / Widower

Mailing Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email Address _____

Class: ☐ Certificated ☐ Classified ☐ Trustee ☐ Management ☐ Confidential ☐ Retiree

BENEFIT PLAN SECTION

Medical Carrier: ☐ Aetna ☐ Anthem Blue Cross ☐ Blue Shield

PPO Plan: ☐ Plan 1 †† ☐ Plan 2 †† ☐ Plan 3 †† ☐ Plan 4 †† ☐ Plan 5 †† ☐ Plan 6 †† ☐ Plan 7 †† ☐ Plan 8 ††
☐ Plan 9 †† ☐ Plan 10 †† ☐ Bronze Plan ☐ Wellness PPO Plan ☐ HDHP 1 ☐ HDHP 2 ☐ HDHP 3
RX PLAN: ☐A ☐B ☐C ☐D ☐ValuRx

EPO Plan: ☐ EPO Premier †† ☐ EPO Prime †† ☐ EPO Saver †† ☐ EPO Value †† ☐ EPO HSA
RX PLAN: ☐A ☐B ☐C ☐D ☐ValuRx

HMO Plans: ☐ Kaiser Permanente: ☐ Kaiser Permanente w/Chiro:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 ☐ Plan 6 ☐ Plan 7 ☐ Plan 8 ☐ Kaiser Wellness ☐ HSA Plan ☐ Bronze DHMO Plan
CVT HMO: ☐ Anthem Blue Cross ☐ Blue Shield
☐ Plan 1 †† ☐ Plan 2 †† ☐ Plan 3 †† ☐ Bronze Plan ††
RX PLAN: ☐A ☐B ☐C ☐D ☐ValuRx

Other Plans: ☐ Dental-Incentive Plan ☐ Dental-PPO Plan ☐ Vision ☐ Life* ☐ EAP

DEPENDENT CODES

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

ADDITIONAL FORMS AND/OR INFORMATION REQUIRED WHEN ADDING OR DELETING DEPENDENTS. IF NOT INCLUDED, IT WILL DELAY ENROLLMENT.

LIST ALL DEPENDENTS

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

DEP CODE*	LAST NAME, FIRST NAME AND MIDDLE INITIAL	GENDER	SOCIAL SECURITY	DATE OF BIRTH	AGE	M D V	ENROLL
						M D V	ADD / DELETE
						M D V	ADD / DELETE
						M D V	ADD / DELETE
						M D V	ADD / DELETE
						M D V	ADD / DELETE

Reason for deleting dependents: _____ (Required)

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

OTHER MEDICAL COVERAGE INFO

Including yourself, do any of the persons listed above have other coverage? ☐ Yes ☐ No

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.
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 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.
This authorization shall become effective immediately and shall remain in effect 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 CV**T** is used for technical and member administration only and is not shared with anyone outside the confines of your health coverage.
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.

Signature _____ Date Signed _____

CVT USE ONLY

*† Additional Forms Required/Plan Enrollment Contingent Upon Approved Zip Codes

†† Select An RX Plan With The Medical Plan