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

CVT HMO Membership Enrollment Form

District Name:

CVT USE ONLY

EMPLOYEE INFORMATION

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

SOCIAL SECURITY NO: XXX-XX-XXXX__________ DATE OF BIRTH: mm/dd/yyyy__________ 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?
No Code	Last Name, First name and Middle Initial Primary Care Physician Name	PCP# Medical Group #	Medical Group Name	☐Y ☐N
No Code	Last Name, First name and Middle Initial Primary Care Physician Name	PCP# Medical Group #	Medical Group Name	☐Y ☐N
No Code	Last Name, First name and Middle Initial Primary Care Physician Name	PCP# Medical Group #	Medical Group Name	☐Y ☐N
No Code	Last Name, First name and Middle Initial Primary Care Physician Name	PCP# Medical Group #	Medical Group Name	☐Y ☐N
No Code	Last Name, First name and Middle Initial Primary Care Physician Name	PCP# Medical Group #	Medical Group Name	☐Y ☐N

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

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 mm/dd/yyyy

*Additional Forms Required