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/CHANGE FORM

District Name ______________________

☐ New Enrollment
Effective Date: ___/___/___
Date of Hire: ___/___/___

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

EMPLOYEE INFORMATION

Last Name ______________ First Name ______________ MI ______ ☐ Male ☐ Female

☐ Married Date of Marriage ______________(Required) ☐ Single ☐ Divorced ☐ Widow / Widower

☐ Domestic Partner* Date of Registration ______________(Required)

Social Security No. ______________ Date of Birth ______________ Age ______

Mailing Address ______________ City ______________ State ______ Zip ______

Home Phone ( ) ______________ Cell Phone ( ) ______________ Email Address ______________

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

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 ☐ Bronze Plan ☐ Wellness PPO Plan ☐ HDHP 1 ☐ HDHP 2

RX Plan: ☐ A ☐ B ☐ C ☐ D

HMO Plans:* Kaiser Permanente:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5 ☐ Plan 6 ☐ Plan 7 ☐ Plan 8 ☐ Kaiser Wellness ☐ HSA Plan ☐ Bronze DHMO Plan

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:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Bronze Plan

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 STATUS
						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 COVERAGE INFORMATION

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.

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.

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.

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

Signature ______________________ Date Signed ______________

*** Additional Forms Required**