Certificated Employees

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

Colusa Unified School District

Effective Date: _____

☐ New Enrollment Date of Hire: _____

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

EMPLOYEE INFORMATION

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

Social Security No. _____ Date of Birth _____ Age _____

Mailing Address _____ City _____ State CA Zip _____

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

Marriage Status: ☐ Married Date of Marriage: _____ ☐ Domestic Partnership: Date of Registration: _____ ☐ Single ☐ Divorced ☐ Widow/Widower

BENEFIT PLAN SECTION

Medical Plans: Check one plan choice: Plan 1A ☐ Plan 4A ☐ Wellness ☐ Plan 8A ☐ Plan 10D ☐ Bronze ☐ HDHP3 ☐

Other Plans: Delta Dental Incentive Plan ☑ Vision Service Plan ☑ Employee Assistance Program ☑

LIST ALL DEPENDENTS

SP-Spouse DP-Domestic Partner CH-Child SC-StepChild DD-Child of DP LG-Legal Guardianship AD-Adoption

M=MEDICAL D=DENTAL V=VISION

Circle M D V for Coverages

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 ☐

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**

REV. 6/2013 RESET

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.**