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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: ___/___/___
☐ Full Time ☐ Part Time

☐ **Enrollment Change Qualifying Event:**
Effective Date: ___/___/___
☐ **Open Enrollment**
☐ **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

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 100 ☐ EPO 90 ☐ EPO 80 ☐ EPO 70 ☐ 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:
☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Bronze Plan

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

DEPENDENT CODES

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

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.

CVT USE ONLY

Signature _____ Date Signed _____

REV. 04/19

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

California Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only.

A. Company information (to be completed by administrator)

Number of pages including this page

Company name

Customer ID*

Enrollment unit ID*

Enrollment unit name/classification

Eligibility contact phone

Plan (example: HMO 20, DHMO 500/30)

Employee Number

Effective date of enrollment/change* (mm/dd/yyyy)

Reason for enrollment if adding subscriber and/or dependent(s)

- ☐ Open enrollment period
- ☐ Birth of eligible dependent
- ☐ Newly eligible, new hire, rehire, or increase in hours
- ☐ Special enrollment period (as described under "Additional information" on page 2) due to triggering event on (mm/dd/yyyy)

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

- ☐ Enroll subscriber (and dependents)
- ☐ Add dependent(s) to existing subscriber account
- ☐ Remove dependent(s) from subscriber account
- ☐ Change name of subscriber and/or dependent(s)
- ☐ Update address
- ☐ Other

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth (mm/dd/yyyy)

Home address* (physical location, no P.O. Box)

City*

State*

ZIP code*

Phone

Mailing address (if different than home)

City

State

ZIP code

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan Arbitration Agreement.† I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

X

Subscriber signature*

Date (mm/dd/yyyy)

*Field required for all enrollments and changes. †Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

KAISER PERMANENTE®

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A–D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth (mm/dd/yyyy)

2 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name* MI* Medical record number (if known)

Last name* Social Security number*

Former name/nickname Date of birth (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber

Home address* (physical location, no P.O. Box)

City State ZIP code

The following special enrollment information applies to coverage under a small group plan: If you decline coverage for yourself or an eligible dependent when you are first eligible to enroll, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or during a special enrollment period if you have experienced a triggering event. You must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court orders that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

*Field required for all enrollments and changes.