



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
Social Security No. Date of Birth Age
Home Phone Cell Phone Email Address
Mailing Address City State Zip
Married Date of Marriage (Required) Single Divorced Widow / Widower
Domestic Partner\* Date of Registration (Required)
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
Wellness PPO Plan HDHP 1 HDHP 2
RX Plan: A B C D
Kaiser Plan:\*\* Plan 1 Plan 2 Plan 3 Plan 4 Plan 5 Plan 6 Plan 7 Plan 8
Other Plans: Dental Vision EAP Life\*\*
\*\* Additional Forms Required

DEPENDENT CODES

SP=Spouse CH=Child DD=Dependent of Domestic Partner AD=Adoption\*
DP=Domestic Partner\* SC=Step Child LG=Legal Guardianship\*
\*Additional Forms Required

Table with 8 columns: DEP CODE, LAST NAME, FIRST NAME AND MIDDLE INITIAL, GENDER, SOCIAL SECURITY, DATE OF BIRTH, AGE, M D V, ENROLL STATUS. Includes header M=MEDICAL D=DENTAL V=VISION (CIRCLE)

Reason for deleting dependents: (Required)

If a dependent is disabled, please indicate name of dependent here:
\*Additional forms and/or information required for domestic partners, disabled dependents, legal guardian, adoption, divorce.

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

Name Insurance Carrier Policy Number Effective Date
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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

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.
Deduction Authorization - If applicable I authorize my employer to deduct from my wages the required contribution.
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 a 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.
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.

CVT USE ONLY

Signature Date Signed
REV. 7/12 WHITE - CVT CANARY - EMPLOYER PINK - SUBSCRIBER