Central Valley
Schools Health & Welfare
Trust

Group Membership Enrollment Form

☐ NEW/OPEN ENROLLMENT ☐ ENROLLMENT CHANGE
EFFECTIVE DATE:_____ ☐ ADDRESS CHANGE
IF CHANGE, YOU MUST GIVE A QUALIFIED REASON:_____

LAST NAME _____ FIRST NAME _____ MI ____
SOCIAL SECURITY NO. _____ DATE OF BIRTH _____ HOME PHONE _____
MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____
CLASS/JOB TITLE _____ HIRE DATE _____ E-MAIL _____

☐ Married ☐ Divorced ☐ Single ☐ Widowed DATE OF MARRIAGE:_____(REQUIRED)

DEPENDENT CODES

SP=SPOUSE
DP-DOMESTIC PARTNER
CH=CHILD
SC=STEP CHILD
DD=DEPENDENT OF DOMESTIC PARTNER
LG=LEGAL GUARDIANSHIP
AD=ADOPTION

BENEFIT PLAN SELECTION

PPO:
BASE ☐
PLAN 1 ☐
PLAN 2 ☐
PLAN 3 ☐
HMO ☐ (ADDITIONAL FORMS REQUIRED)
DELTA DENTAL ☐
Incentive ☐ DPO 1 ☐ DPO 2 ☐
VSP ☐
EAP ☐
LIFE ☐ (ADDITIONAL FORMS REQUIRED)

LIST ALL DEPENDENTS

M=MEDICAL D=DENTAL V=VISION (CIRCLE)

DEP.CODES	LAST NAME, FIRST NAME AND MIDDLE INITIAL	GENDER	SOCIAL SECURITY NO.	DATE OF BIRTH	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
					M D V	ADD/DELETE
					M D V	ADD/DELETE
					M D V	ADD/DELETE

IF A DEPENDENT IS DISABLED, PLEASE INDIC[illegible] _____

REASON FOR DELETING DEPEND[illegible] _____(REQUIRED)

*ALL DEPENDENTS 19 YEARS OR [illegible] DEPENDENT OR A FULL-TIME STUDENT (12 UNITS OR MORE).
*ADDITIONAL FORMS AND/OR INFO REQU[illegible] ERS, OVERAGE AND DISABLED DEPENDENTS, LEGAL GUARDIAN, ADOPTION, DIVORCE.

SAMPLE ONLY

MEDICARE SECTION

ARE YOU RETIRED?.....☐YES ☐NO
IF YES, DO YOU HAVE MEDICARE?.....☐YES ☐NO
PART A.....☐YES ☐NO EFFECTIVE DATE_____
PART B.....☐YES ☐NO EFFECTIVE DATE_____

DO ANY OF YOUR DEPENDENTS HAVE MEDICARE?....☐YES ☐NO
IF YES FOR YOUR DEPENDENTS:
PART A.....☐YES ☐NO EFFECTIVE DATE_____
PART B.....☐YES ☐NO EFFECTIVE DATE_____

COORDINATION OF BENEFITS

IF YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH COVERAGE THROUGH ANOTHER SOURCE YOU MUST PROVIDE THE FOLLOWING INFORMATION:

NAME OF INSURED	CARRIER NAME	GROUP OR ID#	SUBSCRIBER NAME

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 CONTRIBUTIONS.
I ACKNOWLEDGE RECEIPT OF CVT'S NOTICE OF PRIVACY PRACTICES AND AUTHORIZE CVT TO OBTAIN AND RELEASE MEDICAL INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS IN ACCORDANCE WITH ITS PRIVACY RULES.
I HEREBY AUTHORIZE MY PHYSICIAN, HEALTH CARE PRACTIONER, HOSPITAL, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY TO FURNISH AN AGENT, DESIGNEE, OR REPRESENTATIVE OF CENTRAL VALLEY TRUST 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 AN APPLICATION OR A CLAIM.
I ALSO AUTHORIZE CENTRAL VALLEY TRUST 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 CENTRAL VALLEY TUST TO PROCESS CLAIMS.
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_____