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

Effective Date: July 1, 2017

District Name: Desert Sands Unified School District

Qualifying Event: (If Applicable) ☒ Open Enrollment

CVT USE ONLY

EMPLOYEE INFORMATION

LAST NAME:_____FIRST NAME_____MI_____ ☐ MALE ☐ FEMALE

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ AGE: _____

MAILING ADDRESS _____CITY_____STATE_____ZIP_____

HOME PHONE ( )_____CELL PHONE ( )_____EMAIL ADDRESS_____

☐ 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

DENTAL : ☐ DENTAL- INCENTIVE PLAN ☐ DENTAL-PPO PLAN VISION: ☐ C

DEPENDENT CODES

ADDITIONAL FORMS AND/OR DOCUMENTATION REQUIRED WHEN ADDING OR DELETING DEPENDENTS. IF NOT INCLUDED, IT WILL DELAY ENROLLMENT.

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

List Dependent(s) To Add or Delete — D=Dental V=Vision (Circle)

Dep Code*	Last Name, First name and Middle Initial	Gender	Social Security	Date of Birth	Age	D V	Enroll Status
						D V	add / delete
						D V	add / delete
						D V	add / delete

Reason for Deleting Dependent(s):_____(Required)

If a dependent is disabled, please indicate name of dependent:_____

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.
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 a claim.
This authorization shall become effective immediately and shall remain in effect as long 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.

Signature _____ Date Signed _____