ACA Benefit Eligible Membership Enrollment 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

District Name: Madera Unified School District

Effective Date:

Employee is associated with an existing CVT bargaining unit: ☐ YES ☐ NO

Qualifying Event: (If Applicable)

- ☐ Open Enrollment
- ☐ Address Change
- ☐ Name Change
- ☐ Add/Remove Dep

CVT USE ONLY- DATE RECEIVED

CVT has established a new plan offering with the following key guidelines:

- Employee is Affordable Care Act (ACA) defined eligible for coverage but not otherwise eligible for benefits
- Employee is not eligible for benefits under a Collective Bargaining Agreement (CBA)
- Plan design is CVT's current PPO Bronze Plan
- Two tier rate structure – Employee or Employee and Child(ren)
- Spouses/domestic partners are not eligible for coverage
- Employees enrolled in this plan cannot be enrolled in CVT dental, vision and/or life plans
- District contribution is not required

EMPLOYEE INFORMATION

NAME: _____ ☐ MALE ☐ FEMALE
(Last, First, Middle Initial)

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

MAILING ADDRESS _____**CITY**_____**STATE**_____**ZIP**_____

STREET ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)_____**CITY**_____**STATE**_____**ZIP**_____

HOME PHONE ( )_____**CELL PHONE ( )**_____**EMAIL ADDRESS**_____

BENEFIT PLAN SECTION

☒ **PPO Bronze Plan**

DEPENDENT CODES

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

Additional forms and/or information required when adding or deleting dependents. If not included, it will delay enrollment.

List Children To Add or Delete

Dep Code*	Last Name, First name and Middle Initial	Gender	Social Security	Date of Birth	Age	Enroll Status
						Add / Delete
						Add / Delete
						Add / Delete
						Add / Delete

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

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

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 DATE COMPLETED

Signature _____ **Date Signed** _____

***Additional Forms Required**