

# HEALTH PLAN ENROLLMENT FORM - COUNTY OF VENTURA

PURPOSE (PLEASE CHECK ONE BOX)

NEW ENROLLMENT  
 OPTIMUM CENSUS EMPLOYEE ENROLLMENT  
 NAME CHANGE/PREVIOUS NAME \_\_\_\_\_  
 MARRIAGE/DATE \_\_\_\_\_  
 ADD DEPENDENTS (S) LISTED BELOW  
 DIVORCE/DATE \_\_\_\_\_  
 CANCEL DEPENDENTS (S) LISTED BELOW/DATE \_\_\_\_\_  
 REASON CANCELED \_\_\_\_\_  
 OTHER/SPECIFY \_\_\_\_\_

**EMPLOYEE INFORMATION**  
 LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DEPARTMENT NAME \_\_\_\_\_ UNION \_\_\_\_\_ HIRE DATE \_\_\_\_\_  
 HOME ADDRESS (No & Street) \_\_\_\_\_ APT No \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME TELEPHONE \_\_\_\_\_ WORK TELEPHONE \_\_\_\_\_

**PLAN ENROLLMENT INFORMATION**

MEDICAL PLAN (NAME) \_\_\_\_\_ VISION PLAN PROVIDER/OPTOMETRY CENTER CODE \_\_\_\_\_

**To enroll yourself & eligible dependents in Medical, Dental and/or Vision plans, complete for EACH person to be covered. Attach a separate sheet with a list of any additional dependents. If enrolled in an HMO medical plan, attach proof of student status for dependent children age 19 or older**

EMPLOYEE	LAST NAME	FIRST NAME	MI	BIRTHDATE (MONTH/DAY/YEAR)	FULL-TIME STUDENT	OTHER INSURANCE?	SOCIAL SECURITY NUMBER	PHYSICIAN NAME/ IPA P/N NUMBER	PREVIOUSLY SEEN?	PRIMARY DENTIST GROUP (DENTAL PANEL ONLY)
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Medicare			<input type="checkbox"/> Yes <input type="checkbox"/> No	

NAME OF SPOUSE/PARTNER'S EMPLOYER \_\_\_\_\_ ADDRESS (NO. & STREET) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 NAME OF INSURANCE COMPANY \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_ TELEPHONE NUMBER ( ) \_\_\_\_\_ NAME OF INSURED(S) \_\_\_\_\_

**ENROLLMENT AUTHORIZATION**

OTHER MEDICAL INS.  OTHER DENTAL INS.  
 OTHER VISION INS.

If you and/or your dependents are insured for Medical, Dental or Vision benefits provided under any other employer, union, student insurance, Medicare, CHAMPUS or other insurance plan, please check the applicable box(es) and complete this section. Attach a separate sheet, if necessary.

I certify the information on this form is complete and correct, and that all dependents listed meet the eligibility rules of the plan(s) in which I have enrolled them. I understand that misstatements, material misrepresentations or omissions may result in my coverage being void as of its effective date with no benefits payable. I understand and agree: (A) that my enrolled dependents and I are bound by all the terms and conditions of the plans in which I have enrolled, and/or release medical information from/to appropriate providers/agencies if needed to provide necessary health care services and/or administrative services and/or claim adjudication for myself and my enrolled dependent(s); this authorization is effective immediately and shall remain in effect for a period of thirty (30) months, except that it shall remain effective for use in connection with any claim for benefits as long as the coverage under the plan I have selected remains in effect. A photocopy of this form is as valid as the original. (C) If a disagreement arises regarding coverage under a plan, the dispute or claim shall be submitted to the grievance and/or binding arbitration process as specified by the plan, and not by lawsuit or resort to court process, except as provided by California law.

EMPLOYEE'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Medical Plan Group I.D. Number (C/S/A/P) \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_ DEPARTMENT AUTHORIZATION/DATE \_\_\_\_\_ HUMAN RESOURCES AUTHORIZATION/DATE \_\_\_\_\_ FOR CARRIER USE ONLY \_\_\_\_\_