Coverage Opt-Out 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:

Effective Date:

☐ **Open Enrollment**

☐ **Qualifying Event**

☐ **Classified**
☐ **Certificated**
☐ **Management**
☐ **Trustee**

**CVT USE ONLY-
DATE RECEIVED**

CVT allows full-time employees to opt-out of bargained coverage under the following guidelines:

- You must provide proof of other qualified employer-sponsored group coverage or TRICARE, Medi-Cal or subsidized Covered California coverage
  - Proof of other coverage must include the employee's name
  - Proof of other coverage must be dated within 31 days of opt-out plan effective date
  - Proof of other coverage is required at the time of the original opt-out and annually during the Open Enrollment period
  - If proof of coverage is not provided the employee will be automatically enrolled in CVT's PPO Bronze plan with an effective date of the original opt-out date
- Enrollment in a medical plan through CVT*, or the opt-out plan, will only be allowed during the Open Enrollment period or if a qualifying event occurs.
  - Proof of continuous other coverage will be required in order to elect CVT plan coverage after opt-out. If other coverage ends prior to CVT's Open Enrollment period, the employee will be enrolled in CVT's PPO Bronze plan with an effective date of first of the month following the loss of other coverage.

EMPLOYEE INFORMATION

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

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

☐ **MARRIED DATE:**_____ ☐ **DOMESTIC PARTNER REGISTRATION DATE:** _____ ☐ **SINGLE** ☐ **DIVORCED** ☐ **WIDOW / WIDOWER**

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

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

AUTHORIZATION - PLEASE READ CAREFULLY

Authorization: I authorize CVT to remove me from any and all medical health benefit coverage offered to me through my employer. I have provided CVT proof of other coverage as required to opt-out of CVT coverage. I acknowledge that by opting-out of CVT coverage, I will not receive medical health benefits through CVT and may not be able to enroll for CVT coverage until an open enrollment date unless a qualifying event occurs. I also acknowledge that by submitting a proof of other coverage I am agreeing that I am voluntarily choosing to enroll in the alternate coverage, which may provide lessor benefits than those offered through CVT. I accept responsibility for any medical costs incurred that I may not have otherwise incurred should I have decided not to opt-out of CVT coverage. I understand that by opting-out of CVT coverage I am no longer entitled to receive medical health benefits through CVT.

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**

* Active employees opted out of CVT coverage are eligible for District-Paid Retiree and/or Self-Paid Retiree coverage if certain criteria are met. See CVT's District-Paid Retiree Guidelines and Self-Paid Retiree Guidelines for criteria requirements.

Signature _____ **Date Signed** _____