County of Ventura
OPT OUT CERTIFICATION FORM

Please Check One

☐ **New Opt-Out** ☐ **Updating Current Opt-Out Info** ☐ **New Opt-Out Open Enrollment**

This form is to be completed by all employees newly enrolling in the Medical Plan Opt Out option <u>OR</u> who are currently enrolled in the Medical Plan Opt Out option and have experienced a change in their other eligible group medical plan coverage.

Employee ID Number: ____ Agency: ______________

Employee Name: ____ DOB: ________________

If you are covered as a dependent under another County of Ventura employee's medical plan, please skip to Section II.

I. Please complete the following for your other eligible group medical plan coverage and attach a copy of the front and back of your ID card:

Subscriber's Name: ____ Zip Code: ____________________

Subscriber's Social Security Number: ________________________ Subscriber's DOB: ______________

☐ Spouse ☐ Registered Domestic Partner ☐ Parent ☐ Self ☐ Other: _______________________

Sponsoring Employer: ____

Subscriber ID No: _________________________________ Group No: _____________________________

Medical Plan Insurance Company: ____

Medical Plan Telephone Number: ____

Coverage Effective Date: ____

II. If you are covered as a dependent under another County of Ventura employee's medical plan, please complete this section (no further documentation is necessary).

Subscriber's Employee ID Number: ____

Subscriber's Name: ____

III. I certify that I have read, understand, and agree to the terms outlined on this form.

I authorize the County of Ventura HR/Benefits to perform any investigation necessary to verify my current enrollment/eligibility for the above-named medical insurance plan, and I attest to the accuracy of the information contained within this form. I further acknowledge that at any time while opting-out of medical coverage, if I lose other eligible group medical plan coverage, I will notify County Benefits within 31 days, in order to enroll in an available County medical plan.

I agree to comply with the County's Flexible Benefit Program, which includes providing updated proof of other eligible group medical plan coverage and meeting eligibility requirements. Failure to comply with these terms and annual audit requirements may result in collection of retroactive medical premiums and/or repayment of cash back received for any period in which I was not able to demonstrate eligibility.

____ ____________________

Signature Date

Please complete & return to County HR/Benefits – Benefits.ServiceRep@ventura.org or Brown Mail #1970

Revised 03/2019