County of Ventura
OPT OUT CERTIFICATION FORM

This form is to be completed by all employees newly enrolling in the Medical Plan Opt Out option or who are currently enrolled in the Medical Plan Opt Out option and have experienced a change in their other comprehensive employer group medical coverage.

Employee ID Number: _____

Employee Name: _____

Date: _____

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 comprehensive employer **group** medical coverage and attach a copy of the front and back of your ID card.

Subscriber's Name: _____

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

Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Sponsoring Employer: _____

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. You must provide updated proof/information when/if your other comprehensive employer group medical coverage changes.

I authorize 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.

_____ _____

Signature Date

Please complete & return to County HR/Benefits – Benefits.ServiceRep@ventura.org or fax 805-654-2665