



# 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 OR who are currently enrolled in the Medical Plan Opt Out option and have experienced a change in their other eligible medical plan coverage. This form must be submitted with mid-year change paperwork and within 31 days of a mid-year change, or a mid-year change will not be approved, no exceptions.*

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 or a letter from the insurer with information on your new coverage. This form must be submitted within 31 days including the event date (the effective start date of outside coverage), no exceptions:**

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