Retiree Health Plan Enrollment & Change Form

Instructions: After completion, please return this form to the County's Retiree Health Benefits Coordinator:
800 S. Victoria Avenue, #1970, Ventura, CA 93009
FAX: (805) 654-2665; Email: Patty.Vandewater@ventura.org

County of Ventura Human Resources/Benefits
800 S. Victoria Ave., #1970, Ventura, CA 93009-1970
(805) 662-6791 · FAX (805) 654-2665
Website: http://ceo.countyofventura.org/benefits

Type of Enrollment

- ☐ New Enrollment_____
- ☐ Change Plan(s) from_____
- ☐ Cancel Plan(s)/Eff Date_____
- ☐ Add/Cancel Dependent/Date & Reason_____
- ☐ Other_____

1. Enrollee Information (please print)

COUNTY RETIREE ☐ **OR**
SURVIVING SPOUSE ☐

NAME (LAST, FIRST, M.I.)	SOCIAL SECURITY NUMBER		DATE OF BIRTH
ADDRESS (NUMBER & STREET)	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**OTHER PHONE**	**GENDER (M/F)**	**RETIREMENT DATE**
FORMER AGENCY/DEPARTMENT NAME	**FORMER UNION**	**EMAIL ADDRESS**	

2. Medical Plan Coverage

Non-Medicare Eligible Retirees and Dependents (retiree and dependent(s) not entitled to or enrolled in Medicare):

- ☐ Ventura County Health Care Plan (HMO)
- ☐ BlueShield Trio ACO HMO (limited network)
- ☐ BlueShield Access+ HMO (full HMO network)
- ☐ BlueShield High-Deductible PPO

Medicare-Eligible Retirees and Dependents (retiree and dependent(s) entitled to and enrolled in Medicare Part A & Part B):

- ☐ Kaiser Senior Advantage (Medicare Replacement Plan)
- ☐ BlueShield Medicare Advantage HMO (Medicare Replacement Plan)
- ☐ BlueShield Medicare COB PPO (coordinates benefits with your Medicare)

- ☐ BlueShield Medicare Advantage HMO / BlueShield Trio ACO HMO (non-Medicare)
- ☐ BlueShield Medicare Advantage HMO / BlueShield Access+ HMO (non-Medicare)
- ☐ BlueShield Medicare Advantage HMO / BlueShield High-Deductible PPO (non-Medicare)
- ☐ BlueShield Medicare COB PPO / BlueShield Trio ACO HMO (non-Medicare)
- ☐ BlueShield Medicare COB PPO / BlueShield Access+ HMO (non-Medicare)
- ☐ BlueShield Medicare COB PPO / BlueShield High-Deductible PPO (non-Medicare)

Medical Plan Monthly Premium: $_____

3. Dental Plan Coverage

- ☐ MetLife Dental PPO

Dental Plan Monthly Premium: $ _____

4. Vision Plan Coverage

- ☐ MES Vision

Vision Plan Monthly Premium: $ _____

Revised 9/4/19

5. Member/Dependent Information (If enrolling in an HMO medical plan, please be sure to designate a primary care physician for yourself and your dependents. You may add additional dependents on a separate sheet of paper.)

NAME (LAST, FIRST, M.I.)	RELATION-SHIP	DATE OF BIRTH	GENDER (M/F)	SOCIAL SECURITY NUMBER	MEDICAL	DENTAL	VISION	PHYSICAN NAME (HMO only)	Previously seen?
	Self	(see page 1)	(see page 1)	(see page 1)	☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐
					☐	☐	☐		☐

6. Other Coverage

Do you and/or your dependent(s) have additional health plan coverage?
Medicare: ☐ No ☐ Yes – Entitlement Date: _____ Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
If yes, provide name of carrier(s), phone number(s), policy number(s), and sponsoring employer.

_____

7. Signature

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 authorize County of Ventura HR/Benefits to perform any investigation necessary to verify eligibility for myself and/or my dependent(s). 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 also understand and agree that:

- This authorization cancels and replaces any authorization I previously signed for the County of Ventura Retiree Health Benefits Program.
- I hereby elect County of Ventura Retiree Health Benefits Program coverage for myself and my eligible dependents listed on this form, in the health plan(s) indicated.
- I authorize the Ventura County Employees' Retirement Association to deduct from my pension payment the amount needed to pay the premiums for the health plan(s) indicated and authorize the Association to adjust the amount of pension deductions necessary should the premium amount change.
- I agree to verify that the enrollments and deductions I have authorized on this form have been implemented and are in place by reviewing my pension statement for accuracy during the first month my selections are effective and periodically thereafter. I agree that the County of Ventura or its agents acting under authorization shall not be liable in any manner for failure or delay in making deductions or payments here authorized.
- I understand that, upon timely notification by me of a processing error, the County of Ventura will make every effort to remedy the error or omission.
- My enrolled dependents and I are bound by all the terms and conditions of the plans in which I have enrolled.
- The plan administrator and health care professionals/facilities/representatives are authorized to obtain and/or release personal and 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).
- A photocopy of this form is as valid as the original.
- 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.

_____

Signature Date

FOR HR USE ONLY					
Medical Plan Group I.D. Number (C/S/A/P)	Dental Plan I.D. Number	Vision Plan I.D. Number	Effective Date	Date to Carrier	Date to VCERA