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
Preferred contact is by email. Email form to
Retiree.Benefits@ventura.org
(805) 477-1580 · FAX (805) 654-2665

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**
		☐ YES ☐ NO	
PREFERRED PHONE	**GENDER (M/F)**	**MEDICARE ELIGIBLE?**	**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:

You will receive a packet of information, including plan options and rates, from the Alight Retiree Health Solutions.

Medical Plan Monthly Premium: $_____

3. Dental Plan Coverage

- ☐ MetLife Dental PPO

Dental Plan Monthly Premium: $ _____

4. Vision Plan Coverage

- ☐ EyeMed Vision

Vision Plan Monthly Premium: $ _____

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5. Member/Dependent Information (If enrolling in an HMO medical plan, please 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	MEDICARE?	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 I 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