



CALIFORNIA'S VALUED TRUST
Healthcare Benefits for the Education Community
520 E. Herndon Ave., Fresno, CA 93720
(800) 288-9870 - FAX (559) 437-2965
www.cvttrust.org

Coverage Opt-Out Form

District Name:				
Effective Date:				
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Classified			
<input type="checkbox"/> Qualifying Event	<input type="checkbox"/> Certificated			
	<input type="checkbox"/> Management			
	<input type="checkbox"/> Trustee			

**CVT USE ONLY-
DATE RECEIVED**

CVT allows full-time employees to opt-out of bargained coverage under the following criteria:

1. If the unit and district have agreed to allow opt-outs and the employee is enrolled in other qualified **employer-sponsored group coverage**.
2. If the employee is enrolled in **TRICARE, Medi-Cal or subsidized Covered California coverage**.

Proof of other coverage must include the employee's name and must be dated within 31 days of the opt-out plan effective date.

Please note:

- Proof of other coverage is required at the time of the original opt-out and annually during the Open Enrollment period
- If proof of coverage is not provided the employee will be automatically enrolled in CVT's PPO Bronze plan with an effective date of the original opt-out date
- Enrollment in a medical plan through CVT*, or the opt-out plan, will only be allowed during the Open Enrollment period or if a qualifying event occurs
- Proof of continuous other coverage will be required in order to elect CVT plan coverage after opt-out. If other coverage ends prior to CVT's Open Enrollment period, the employee will be enrolled in CVT's PPO Bronze plan with an effective date of first of the month following the loss of other coverage
- Employees enrolled in the opt out plan will continue to be subject to CVT's 100% participation in the group's dental, vision and group term life plans if offered.

EMPLOYEE INFORMATION

NAME: _____ MALE FEMALE
(Last, First, Middle Initial)

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ AGE: _____

MARRIED DATE: _____ DOMESTIC PARTNER REGISTRATION DATE: _____ SINGLE DIVORCED WIDOW / WIDOWER

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ CELL PHONE () _____ EMAIL ADDRESS _____

AUTHORIZATION - PLEASE READ CAREFULLY

Authorization: I authorize CVT to remove me from any and all medical health benefit coverage offered to me through my employer. I have provided CVT proof of other coverage as required to opt-out of CVT coverage. I acknowledge that by opting-out of CVT coverage, I will not receive medical health benefits through CVT and may not be able to enroll for CVT coverage until an open enrollment date unless a qualifying event occurs. I also acknowledge that by submitting a proof of other coverage I am agreeing that I am voluntarily choosing to enroll in the alternate coverage, which may provide lesser benefits than those offered through CVT. I accept responsibility for any medical costs incurred that I may not have otherwise incurred should I have decided not to opt-out of CVT coverage. I understand that by opting-out of CVT coverage I am no longer entitled to receive medical health benefits through CVT.

**CVT USE ONLY
DATE COMPLETED**

Email Address: The information you are asked to provide to CVT is used for technical and member administration only and is not shared with anyone outside the confines of your health coverage.

I acknowledge that legal action to resolve any benefit dispute will be through arbitration.

I declare, under penalty of perjury under the laws of the State of California, that the foregoing is true and correct.

* Active employees opted out of CVT coverage are eligible for District-Paid Retiree and/or Self-Paid Retiree coverage if certain criteria are met. See CVT's District-Paid Retiree Guidelines and Self-Paid Retiree Guidelines for criteria requirements.

Signature _____

Date Signed _____