



# 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: \_\_\_\_\_

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- 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: \_\_\_\_\_

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- 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