Employer Name	Employee Last Name	Employee First Name	Employee ID No.	Effective Date - for HR Use Only

Member Enrollment Application / Change Form

Valley Health Plan

Please print in black or dark blue ink. Retain a copy for your records.

REASON FOR APPLICATION

☐ New Hire ☐ Open Enrollment ☐ Dependent Contractor/Extra-Help
☐ Loss of Prior Coverage ☐ COBRA/Cal-COBRA ☐ Retiree - Classic Plan
Date: MM / DD / YY ☐ Retiree - Preferred Plan

REASON FOR CHANGE

☐ Address Change ☐ Name Change
☐ Delete Dependent(s) ☐ Add Other Coverage
☐ Add Dependent(s) - (circle one) Marriage / Birth / Adoption - Date: MM/ DD / YY

VHP ID# - for VHP Use Only

SUBSCRIBER INFORMATION

Social Security Number	Legal Last Name	Legal First Name	M.I.	Date of Birth	Gender ☐M ☐F	Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partnership

Home Address	City	State	Zip Code	Home Phone ( ) –	Work Phone ( ) –

Mailing Address (if applicable)	City	State	Zip Code	Department	Employee Type ☐ Active ☐ Retired

E-mail Address (optional)	Preferred Language Spoken	Preferred Language Written	VHP Primary Physician (PCP) Name (Last, First)	Current Patient ☐Yes ☐No	Date of Hire MM/DD/YY	Date of Rehire MM/DD/YY

Ethnicity (optional):
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Other
☐ Hispanic or Latino ☐ Russian ☐ Vietnamese PLEASE SPECIFY ETHNICITY

Race (optional):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multi-Racial PLEASE SPECIFY RACE

DEPENDENT INFORMATION – List all persons covered by this application. Only your spouse/domestic partner and unmarried dependent children may be included.

Spouse/Domestic Partner — Legal Last Name	Legal First Name	M.I.	Date of Birth MM / DD / YYYY	Gender ☐M ☐F	Social Security Number

E-mail Address (optional)	Preferred Language Spoken	Preferred Language Written	VHP Primary Physician (PCP) Name (Last, First)	VHP ID# - for VHP Use Only

Ethnicity (optional):
☑ Asian Indian ☐ Chinese ☐ Filipino ☐ Other
☑ Hispanic or Latino ☐ Russian ☐ Vietnamese PLEASE SPECIFY ETHNICITY

Race (optional):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multi-Racial PLEASE SPECIFY RACE

Child — Legal Last Name	Legal First Name	M.I.	Date of Birth MM / DD / YYYY	Gender ☐M ☐F	Social Security Number

E-mail Address (optional)	Preferred Language Spoken	Preferred Language Written	VHP Primary Physician (PCP) Name (Last, First)	VHP ID# - for VHP Use Only

Ethnicity (optional):
☑ Asian Indian ☐ Chinese ☐ Filipino ☐ Other
☑ Hispanic or Latino ☐ Russian ☐ Vietnamese PLEASE SPECIFY ETHNICITY

Race (optional):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multi-Racial PLEASE SPECIFY RACE

Child — Legal Last Name	Legal First Name	M.I.	Date of Birth MM / DD / YYYY	Gender ☐M ☐F	Social Security Number

E-mail Address (optional)	Preferred Language Spoken	Preferred Language Written	VHP Primary Physician (PCP) Name (Last, First)	VHP ID# - for VHP Use Only

Ethnicity (optional):
☑ Asian Indian ☐ Chinese ☐ Filipino ☐ Other
☑ Hispanic or Latino ☐ Russian ☐ Vietnamese PLEASE SPECIFY ETHNICITY

Race (optional):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multi-Racial PLEASE SPECIFY RACE

Child — Legal Last Name	Legal First Name	M.I.	Date of Birth MM / DD / YYYY	Gender ☐M ☐F	Social Security Number

E-mail Address (optional)	Preferred Language Spoken	Preferred Language Written	VHP Primary Physician (PCP) Name (Last, First)	VHP ID# - for VHP Use Only

Ethnicity (optional):
☑ Asian Indian ☐ Chinese ☐ Filipino ☐ Other
☑ Hispanic or Latino ☐ Russian ☐ Vietnamese PLEASE SPECIFY ETHNICITY

Race (optional):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Other
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Multi-Racial PLEASE SPECIFY RACE

COMPLETE BOTH SIDES OF THIS APPLICATION, SIGN, DATE, AND RETURN TO EMPLOYER.

PREFERRED METHOD OF CONTACT

What is the best way for us to contact you by?

❑ Home Phone ❑ Work Phone ❑ Home Address ❑ Mailing Address ❑ E-mail:_____ ❑ Other: PLEASE SPECIFY

OTHER MEDICAL INSURANCE

Do you and/or any of your eligible family members (dependents) have other medical insurance (including Medicare) in addition to your Valley Health Plan coverage?

❑ No ❑ Yes: ❑ Self ❑ Spouse/Domestic Partner ❑ Children — If coverage is through other parent, please indicate other parent's date of birth: MM/ DD / YYYY

Insured's – Last Name	First Name	M.I.	Other Insurance Name	Social Security Number	Group Number
Address of Insurance Company			City	State	Zip Code
Insured's – Last Name	First Name	M.I.	Other Insurance Name	Social Security Number	Group Number
Address of Insurance Company			City	State	Zip Code
Insured's – Last Name	First Name	M.I.	Other Insurance Name	Social Security Number	Group Number
Address of Insurance Company			City	State	Zip Code

GENERAL INFORMATION

IMPORTANT: Can you read this document? If not, we can have somebody help you read it. You may also be able to get this document written in your language. For free help, please call right away at 1.888.421.8444 (toll-free).

IMPORTANTE: ¿Puede leer esta documento? Si no, alguien le puede ayudar a leerla. Además, es posible que reciba esta documento escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al 1.888.421.8444 (número gratuito).

QUAN TRỌNG: Quý vị có đọc được tài liệu không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận tài liệu này bằng tiếng Việt. Để được giúp đỡ miễn phí, xin gọi ngay số 1.888.421.8444 (miễn phí).

Please complete this application enrollment or change form accurately. If you have any questions about your coverage or completing this form contact your employer or Valley Health Plan (VHP). Your new or revised VHP identification card will be mailed to your address in VHP's files. Contact your employer to ensure your VHP membership records are updated.

If you do not select a participating Primary Care Physician (PCP) for yourself and each of your eligible dependents, a PCP will be selected for you.

Your eligible dependent may be covered up to age 26. Please check with your employer to see if your dependent qualifies.

Except in an emergency or prior authorized situation, you should be aware that your VHP benefit plan requires you to obtain all covered services from VHP providers.

ACKNOWLEDGEMENTS AND SIGNATURE

IN COMPLETING THE APPLICATION FOR VALLEY HEALTH PLAN MEMBERSHIP FOR MYSELF AND ELIGIBLE FAMILY MEMBERS, I ACKNOWLEDGE THE FOLLOWING:

1. All benefits received must be provided or authorized by the Valley Health Plan;
2. Valley Health Plan is authorized to obtain and release medical information in compliance with the Insurance Information and Privacy Protection Act, Section 791 et. Seq. of the California Insurance Code; and
3. I and persons listed shall abide by the provisions of the Service Agreement and Health Plan regulations.

Employee Signature	Date
X	

COMPLETE BOTH SIDES OF THIS APPLICATION, SIGN, DATE, AND RETURN TO EMPLOYER.

Valley Health Plan