VENTURA COUNTY
HEALTH CARE PLAN
A Department of Ventura County Health Care Agency

COORDINATION OF BENEFITS INFORMATION

ACTION NEEDED, ONLY IF YOU OR ONE OF YOUR COVERED DEPENDENTS HAS OTHER COVERAGE, OR IF THE OTHER COVERAGE IS NO LONGER EFFECTIVE.

The Ventura County Health Care Plan (VCHCP) is required to annually verify whether members have other health insurance coverage. Therefore, please provide the following information for each individual covered under VCHCP.

Employee Name: ______________________ | Date of Birth: ____________

Other Insurance: ☐ **Yes** ☐ **No** If yes, please complete the information below.

Other Insurance Company Name: ______________________

Other Insurance Effective date (or termination date, if applicable): ______________________

Other Insurance Information: ______________________ (Subscriber's Name) ______________________ (Subscriber's Date of Birth)

______________________ (Subscriber's relationship to the dependent) ______________________ (Other Insurance Group/ID Number)

Spouse/Dependent Name: ______________________ | Date of Birth: ____________

Other Insurance: ☐ **Yes** ☐ **No** If yes, please complete the information below.

Other Insurance Company Name: ______________________

Other Insurance Effective date (or termination date, if applicable): ______________________

Other Insurance Information: ______________________ (Subscriber's Name) ______________________ (Subscriber's Date of Birth)

______________________ (Subscriber's relationship to the dependent) ______________________ (Other Insurance Group/ID Number)

Dependent Name: ______________________ | Date of Birth: ____________

Other Insurance: ☐ **Yes** ☐ **No** If yes, please complete the information below.

Other Insurance Company Name: ______________________

Other Insurance Effective date (or termination date, if applicable): ______________________

Other Insurance Information: ______________________ (Subscriber's Name) ______________________ (Subscriber's Date of Birth)

______________________ (Subscriber's relationship to the dependent) ______________________ (Other Insurance Group/ID Number)

Dependent Name: ______________________ | Date of Birth: ____________

Other Insurance: ☐ **Yes** ☐ **No** If yes, please complete the information below.

Other Insurance Company Name: ______________________

Other Insurance Effective date (or termination date, if applicable): ______________________

Other Insurance Information: ______________________ (Subscriber's Name) ______________________ (Subscriber's Date of Birth)

______________________ (Subscriber's relationship to the dependent) ______________________ (Other Insurance Group/ID Number)

(Continued) ➡

2220 E. Gonzales Road, Suite 210-B • Oxnard, California 93036 • (805) 981-5050 or (800) 600-8247
FAX: (805) 981-5051 • vchealthcareplan.org

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If you need to provide information for additional dependents, please attach a separate sheet with the required information.

It is essential that you notify the Plan of any insurance coverage changes (whether you or your dependents become covered under another Plan/Insurance Company, or if coverage ends with another Plan/Insurance Company).

Employee Name: _____ Signature: _____

Member ID: _____ Date: _____

Please mail, fax, or email this completed form to:

Ventura County Health Care Plan
Attn: Member Services
2220 E. Gonzales Road, Suite 210-B
Oxnard, CA 93036

Fax #: (805) 981-5051
Email: VCHCP.Memberservices@ventura.org

If you have any questions, please contact our Member Services Department at (805) 981-5050 or (800) 600-8247, Monday through Friday from 8:30 a.m. to 4:30 p.m.

Sincerely,
Member Services