



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) 



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

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@venturacounty.gov

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