VENTURA COUNTY
HEALTH CARE PLAN

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 verify whether or not members have other health insurance coverage. Therefore, please provide the following information for each individual covered under your plan with VCHCP.

Employee Name	Date of Birth	Other Insurance (Yes or No): (if yes, complete boxes D – F)
(D) Other Insurance Company Name	(E) Other Insurance Effective date (or termination date, if applicable)	(F) Other Insurance Information: a. Subscriber's Name: _____ b. Subscriber's D.O.B.: _____ c. Subscriber's relationship to the dependent: _____ d. Other Insurance Group/ID Number: _____

Spouse Name	Date of Birth	Other Insurance (Yes or No): (if yes, complete boxes D – F)
(D) Other Insurance Company Name	(E) Other Insurance Effective date (or termination date, if applicable)	(F) Other Insurance Information: a. Subscriber's Name: _____ b. Subscriber's D.O.B.: _____ c. Subscriber's relationship to the dependent: _____ d. Other Insurance Group/ID Number: _____

Dependent Name	Date of Birth	Other Insurance (Yes or No): (if yes, complete boxes D – F)
(D) Other Insurance Company Name	(E) Other Insurance Effective date (or termination date, if applicable)	(F) Other Insurance Information: a. Subscriber's Name: _____ b. Subscriber's D.O.B.: _____ c. Subscriber's relationship to the dependent: _____ d. Other Insurance Group/ID Number: _____

Dependent Name	Date of Birth	Other Insurance (Yes or No): (if yes, complete boxes D – F)
(D) Other Insurance Company Name	(E) Other Insurance Effective date (or termination date, if applicable)	(F) Other Insurance Information: a. Subscriber's Name: _____ b. Subscriber's D.O.B.: _____ c. Subscriber's relationship to the dependent: _____ d. Other Insurance Group/ID Number: _____

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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, Monday through Friday from 8:30 a.m. to 4:30 p.m.

Sincerely,
Member Services