



# Health Care Fund Application

Fields indicated with (\*) are required.

This application is used to apply and enroll eligible child care providers in the **CCPU Health Care Fund Benefits Program**. Once your eligibility is confirmed, you and your eligible family members will automatically receive access to a valuable package of **no-cost health care benefits** designed to support your well-being and financial security (except Basic Group Term Life and AD&D, which are provider-only).

**IMPORTANT:**

The CCPU Health Care Fund is **not health insurance**. You are encouraged to maintain your own medical coverage through Medi-Cal, Covered California, or another health plan of your choice.

**YOUR INFORMATION**

*First Name	Middle Name	*Last Name	Suffix (i.e., Jr, Sr, I, II, III)
*Email	*Mobile Number	*Birth Date (mm/dd/yyyy)	*Social Security / ITIN <input type="checkbox"/> I don't have one
*Mailing Address			
*City	*State	*Postal Code	
Home Address (if different than mailing address above)			
City	State	Postal Code	
*Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese (Simplified) <input type="checkbox"/> Chinese (Traditional) <input type="checkbox"/> Other	*Preferred Method of Communication (select one) <input type="checkbox"/> Mail <input type="checkbox"/> E-Mail	
*What type of provider are you? <input type="checkbox"/> Licensed: License Number _____ <input type="checkbox"/> Family, Friends, and Neighbors / License Exempt <input type="checkbox"/> Not sure			
Business Name	How many subsidized children do you work with? <input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5+	Are you a member of Child Care Providers United? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	
Ethnicity <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Do not want to specify			

**LIST ALL DEPENDENTS YOU WOULD LIKE TO ADD (ATTACH ADDITIONAL PAGES IF NEEDED)**

Complete this portion of the application if you wish to extend your benefits to eligible dependents/household family members.

*Name (Last, first, middle initial)	*Full Time Student?	*Gender (M/F)	*Birthdate (mm/dd/yyyy)	*Relationship (Spouse/Domestic Partner/Child)	*SSN/ITIN
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> Yes <input type="checkbox"/> No				

**Family Eligibility Documentation**

To add your eligible family members to your CCPU Health Care Fund record, you must provide proof of relationship for each dependent, spouse, or registered domestic partner you listed above. This information is required to confirm eligibility for Core Benefits only.

Please attach one of the following documents for each family member you wish to add:

- Marriage Certificate (spouse)
- Registered Domestic Partnership Certification (RDP)
- Birth Certificate (child)
- Adoption Decree
- Tax document verifying tax household (prior year or current year only)

If you plan to apply for Reimbursement Benefits and intend to extend those benefits to your eligible family members:

Please review "Reimbursement Benefits: Submitting Your Proof of Coverage" on the following page to ensure you submit the correct insurance documentation for yourself and your family members.

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**OPTIONAL: REIMBURSEMENT BENEFITS & SUBMITTING YOUR PROOF OF COVERAGE**

If you want to apply for **Health Care Reimbursement Benefits** for yourself and eligible family members, you must submit documentation that confirms each person's **active qualified health plan (QHP)**. Your proof of coverage should show:

- The policy holder's name & Covered household members
- The health plan name/carrier
- Active coverage dates for the year of application
- Monthly premium amount (if applicable)

**Program Rule: All Eligible Family Members Must Be on ONE QHP**

To receive Reimbursement Benefits, your entire eligible household must be enrolled in **one single QHP** together. **This rule applies to all QHPs in this program.\***

**Exceptions\***

There are only **four** exceptions where family members may have different plans:

1. **Covered California (CCA)**
2. **Medi-Cal**
3. **Medicare or Medicare Advantage**
4. **Medi-Medi (dual eligible)**

If your family falls into one of these mixed-plan scenarios, you must submit proof of coverage for each person applying for reimbursement based on their own plan type.

**When Your Household Is on One Plan (Most Common)**

Submit **one** health plan document that lists all covered family members:

- Premium billing statement
- Certificate of coverage
- Open enrollment/renewal confirmation
- Plan summary pages
- Verification of Benefits

**When Household Members Have Different Plans**

Submit proof for each person applying for reimbursement, based on their plan type:

**Medi-Cal:**

- Medi-Cal ID + recent 1095-B, or Verification/Redetermination of Benefits

**Medicare/Advantage:**

- Premium billing (Parts B/D), or Medicare card + eligibility letter

**Covered California:**

- Billing statement, certificate of coverage, or plan summary (showing APTC if applicable)

**YOUR HEALTH PLAN**

(Complete this section and provide proof of coverage to receive Reimbursement Benefits - Not required to apply to the Health Care Fund.)

\*(Check One) Please select your current Health Insurance. Note: If you select Employer Plan, you'll need to identify if you're the employee or dependent.

Covered California – Plan Name: \_\_\_\_\_

Employer Plan      If selected:  Employer Plan as Employee    Employer Plan as Dependent    Veterans/Tricare Plan

<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicare Advantage	<input type="checkbox"/> Both Medi-Cal and Medicare (Medi-Medi-Plan)	<input type="checkbox"/> Carrier Direct (Undocumented Only)
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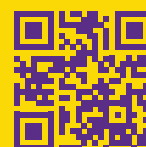
I do not have a qualified health plan and need assistance with enrollment

If selected: Household Size \_\_\_\_\_ Household Income \_\_\_\_\_

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**TO SUBMIT PLEASE EMAIL, FAX OR MAIL THIS COMPLETED APPLICATION WITH PROOF OF COVERAGE (SEE BACK) TO:**

apply@ccpuhealth.org | Fax: (949) 809-8920 | Child Care Providers United – California  
 Workers Health Care Fund, P.O. Box 57027 Irvine, CA 92619  
 Additional Help: (833) 714-6028



APPLY ONLINE FOR FASTER PROCESSING, PLEASE VISIT  
[WWW.CCPUHEALTH.ORG](http://WWW.CCPUHEALTH.ORG)

**SIGN AND ACKNOWLEDGE**

**ELIGIBILITY CONFIRMATION & NEXT STEPS**

Your eligibility will be verified using state-subsidized payment records provided by your Alternative Payment Program or Resource & Referral Agency.

You do **not** need to submit proof of insurance or premium documentation.

Once your eligibility is verified:

You will be automatically enrolled in CCPU Core Benefits. If you are interested in **Reimbursement Program benefits**, please review the section above, **OPTIONAL: REIMBURSEMENT BENEFITS & SUBMITTING YOUR PROOF OF COVERAGE** for additional steps.

If approved, you will receive a Welcome Packet with benefit details and benefit partner contact information.

Your coverage will remain active as long as you continue to meet program eligibility requirements.

I, the undersigned, understand and agree that:

- The CCPU Health Care Fund is not health insurance.
- I must select and maintain coverage in a qualifying health insurance plan that has been approved by the Board of Trustees to receive any CCPU Health Care Fund benefits.
- My spouse, domestic partner, and dependents are not eligible for any CCPU Health Care Fund benefit.
- I have to pay my own premiums for qualifying health plan insurance coverage.
- I must timely respond to all notices and requests for information from the CCPU Health Care Fund and its affiliates, failure to do so may delay or interrupt my benefits through this program.
- We will keep you informed about your submitted application through your preferred method of communication, either by email or mail. Please note, this does not apply to communications for reimbursement requests – it is mandatory to send these types of communications electronically.

I attest that the information in this application is true and accurate. I understand that if I provide incomplete, false or misleading information, my application may be denied, my participation in the CCPU Health Care Fund may be terminated, and my claims may be denied. I will inform the CCPU Health Care Fund about any changes to the information in this application within 30 days of the change. I also understand that submitting this application does not guarantee my benefits or enroll me in a health benefit plan or health insurance coverage through Covered California or any other insurance carrier. I agree to indemnify and hold the CCPU Health Care Fund and the Board of Trustees harmless from any liability for payment of benefits made based upon any of information that is inaccurate or false and to repay any benefits that I incorrectly received.

\*Signature

\*Date (mm/dd/yyyy)

