CCPU HEALTH CARE FUND

Health Care Fund Dependent Enrollment Form

Use this form to add or update household and dependent information for your existing CCPU Health Care Fund records. This enables the Fund to verify which family members are eligible to receive Core Benefits (Dental, Vision, and EAP) under your enrollment.
In order to be complete, you must also attach proof of relationship or proof of tax household for family members to be added to Core Benefits. For family Reimbursement benefit access, you must also submit Proof of Coverage for your dependents. (Please see Section B for guidance)

IMPORTANT PROGRAM INFORMATION

- Eligible family members may receive **core benefits at no cost** (Dental, Vision, and PAP) once eligibility verification is complete.
- **Basic Group Term Life and AD&D are Provider-only** benefits and are not extended to family members.
- Optional Voluntary Life may be available to family members if the employee elects coverage.

A. PROVIDER/DEPENDENT INFORMATION

Please complete all fields and attach any documents required for identity/relationship verification. Section B below provides documentation guidance.
Fields indicated with (*) are required.

CCPU PROVIDER

*Last Name	*First Name	Middle Name	*Age
*Birth Date (mm/dd/yyyy)	*Health Care Fund ID U-Number		*Gender ☐ Male ☐ Female
*Home Phone	Work Phone	*E-mail Address	
*Home Address		*County	
*City	*State	*ZIP	

MAILING ADDRESS (IF DIFFERENT THAN LISTED ABOVE)

Mailing Address		County
City	State	ZIP

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

*Name (Last, first, middle initial)	*Full Time Student?	*Gender (M/F)	*Birthdate (mm/dd/yyyy)	*Relationship (Spouse/ Domestic Partner/Child)	*SSN/ITIN
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

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, Family Benefits, P.O. Box 57027, Irvine, CA 92619
Additional Help: (833) 714-6028

APPLY ONLINE FOR FASTER PROCESSING, PLEASE VISIT
WWW.CCPUHEALTH.ORG

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B. PROOF OF ELIGIBILITY

To add a dependent to your CCPU Health Care Fund benefits, you must provide documentation that confirms your familial or household relationship to the dependent.

The Fund no longer requires Proof of Coverage (POC) for enrollment in Fund Benefits, but you may still submit POC as a way to verify relationship **and** to meet documentation requirements if you also have Reimbursement Program Benefits.

DEFINITIONS

Dependent: A child or other individual for whom a parent, relative, or other person may claim a personal exemption or tax deduction.

Spouse: An individual who is lawfully married to another.

Registered Domestic Partner (RDP): Individuals of the same or opposite sex who are in a registered domestic partnership, union, or other similar formal civil relationship recognized under state law.

Tax Household: The taxpayer(s) and any individuals claimed as dependents on one federal income-tax return. A tax household may include a spouse and/or dependents.

ACCEPTABLE DOCUMENTATION

To verify your relationship, attach **one** (1) of the following documents:

- Marriage Certificate (showing legal marriage to the provider)
- Birth Certificate or Adoption Decree (listing the provider as a parent or guardian)
- Registered Domestic Partnership Certificate
- Recent Tax Document (federal or state return) verifying that the dependent or spouse is part of your tax household (prior year or current year only)

OPTIONAL PROOF OF COVERAGE (POC)

While not required for Fund Benefit eligibility, you may submit **one** of the following if available. Doing so both verifies your relationship and meets the documentation requirement for Reimbursement Program Benefits:

- Copy of a qualified health plan billing statement showing dependent/spouse/RDP covered on the same plan as the provider or
- Copy of employer-sponsored coverage benefits confirmation listing dependent/spouse on the same plan as the provider

Special Rule for Medicare / Covered California / Medi-Cal Households

If the childcare provider is enrolled in a Medicare plan or has a split household between CCA, Medicare and/or Medi-Cal, they must attach:

One document from List A and at least **one** document from List B:

LIST A:

1. Copy of a Medicare premium billing statement, or
2. Medi-Cal verification of benefits form, or
3. Copy of Covered California health plan summary pages

LIST B:

1. Marriage Certificate
2. Birth Certificate or Adoption Decreee
3. Tax Document verifying tax household (prior year or current year only)

C. AFFIRMATION, UNDERSTANDING & DISCLOSURE AUTHORIZATION

I understand that I am applying for CCPU Health Care benefits to be extended to my family members.

I affirm that the foregoing answers on the application are complete and correct. I understand that no coverage will be in effect for my family members until the application and accompanying documents are verified and accepted.

1. If approved, family members will only maintain Health Care Fund benefits as long as the primary childcare provider maintains eligibility.
2. If dependents are added, they can only remain on these benefits until the age of 26, and they will be removed at the end of their birthday month. (Exceptions apply if the dependent is an overage disabled dependent.)
3. If any household member becomes a childcare provider and begins receiving state subsidized payments for the care of a child, they can be removed from their family plan and begin their own CCPU Health Care plan benefits as long as they meet all eligibility criteria.

_____ **CCPU Childcare provider MUST Initial here showing you have read and understand the above paragraph.**

SIGN AND ACKNOWLEDGE

I, the undersigned, understand and agree that:
- **This is an addendum to my application to add healthcare benefits for my spouse, domestic partner, and/or dependents.**

I attest that the information in this application addendum is true and accurate. I understand that if I provide incomplete, false or misleading information, my application and this addendum 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 benefits for my family or enroll my family 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)

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