

## 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 on an annual basis 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	<b>Other Insurance (Yes or No):</b>  <b>(if yes, complete boxes D – F)</b>
(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	<b>Other Insurance (Yes or No):</b>  <b>(if yes, complete boxes D – F)</b>
(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	<b>Other Insurance (Yes or No):</b>  <b>(if yes, complete boxes D – F)</b>
(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	<b>Other Insurance (Yes or No):</b>  <b>(if yes, complete boxes D – F)</b>
(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: _____

(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@ventura.org](mailto: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