

(800) 558-8003 • www.calchoice.com

**Employer Change Request Form** 

E-mail: gpc@choiceadmin.com

A. CHANGE ADDRESS/PHONE/FAX   Please list the group's new billing address below: (	Company Name Group #	
Please remove the contacts listed below:   Check here if billing address and street address are the same)  Croup's new billing address  Street		
Please remove the contacts listed below:   Check here if billing address and street address are the same)  Croup's new billing address  Street	A CHANCE ADDRESS/BHONE/EAV	
Street  County  County  State  City  County  Check here if phone and/or fax # has not changed because the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the group. To addr/change more contacts, complete section 8 on an additional application.  ADD BROKER OF RECORD AS AUTHORIZED GROUP CONTACT  I understand that by electing to add my Broker of Record as an Authorized Group Contact, my Broker of Record will have the ability to make changes on behalf of my group, which may result in a change in premium(s) and/or cancellation of coverage(s).  Primary Contact  E-mail Address  Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:  Remove Contact  C. CHANGE INVOICE OPTION  Be-mail Only Paper Only Both  CHANGE PAY PERIOD  Select the number of pay periods (Will be shown on Employee Enrollment Worksheets)  12		
County  State  City  Croup's new street address Street  City  Check here if phone and/or fax #   Phone # (XXX) XXX-XXXXX   Fax # (XXXX) XXX-XXXXX   Fax # (XXXXXXXXXXXXXXXX   Fax # (XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX		
County  County  Check here if phone and/or fax # State	Street	
County  County  Check here if phone and/or fax # State	County State 7IP Code	
County  Check here if phone and/or fax # has not changed  B. ADD/CHANGE CONTACT  Please add the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the group. To add/change more contacts, complete section B on an additional application.  ADD BROKER OF RECORD AS AUTHORIZED GROUP CONTACT  I understand that by electing to add my Broker of Record as an Authorized Group Contact, my Broker of Record will have the ability to make changes on behalf of my group, which may result in a change in premium(s) and/or cancellation of coverage(s).  Primary Contact  Title/Position  Direct Phone # (XXX) XXX-XXXX		
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Check here if phone and/or fax #		
Check here if phone and/or fax #		
B. ADD/CHANGE CONTACT	County State ZIP Code	
B. ADD/CHANGE CONTACT		
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Direct Phone # (XXX) XXX-XXXX		ly to make
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□ 12 □ 24 □ 26 □ 48 □ 52	C. CHANGE INVOICE OPTION	
		ent Worksheets)
E. ADD/CHANGE LIFE INSURANCE		
Groups wishing to apply for Life amounts higher than the guaranteed issue amounts below must be medically underwritten. Please contact our Customer Service Center for more information.		e contact our
Requirements: 1. 100% of eligible employees (whether enrolling or waiving medical) must enroll for life coverage. Employee Enrollment Applications (Form CC 0310) must be submitted by each employee with Sections A, D, & E completed.		nt
2. A reconciled quarterly/annual wage report must be submitted with all  Guaranteed Issue Amounts  Guaranteed Issue Amounts	2. A reconciled quarterly/annual wage report must be submitted with all  Guaranteed Issue Ar	
employees accounted for (i.e. E=eligible, P1=part-time, S=seasonal, etc.)  Eligible Employees   Minimum   Maximum    1-5   \$5,000   \$5,000	Englishe Employees Millimit	
Select a Flat amount 6-10 \$5,000 \$10,000	Select a Flat amount 6-10 \$5,00	0 \$10,000
for all employees         Amount \$	for all ampleyons	

## ▼ ▼ ▼ ▼ CHIROPRACTIC/ACUPUNCTURE. DENTAL AND VISION CHANGES MAY ONLY BE MADE ONCE A YEAR ▼ ▼ ▼ ▼ F. ADD CHIROPLUS ☐ Chiropractic Only ☐ Chiro & Acupuncture To add the following benefits as an option for your employees, complete the forms indicated below (Login at www.calchoice.com to download forms) G. ADD DENTAL \*Complete the Dental Application (Form # CC 0566) **H. ADD VOLUNTARY VISION** \*Complete the Voluntary Vision Application (Form # CC 0285) I. ADD SECTION 125\* **Participation Limitations:** 1. Name of Company President, Principal, or Partners 2. Name of Corporate Secretary (if applicable) P.O.P. rules require that all participants in the plan be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole 3. Plan # 4. State of Incorporation (usually 501) Proprietors in a Sole Proprietorship and Partners in a (If not indicated, 501 will be used) (if applicable) Partnership are not considered employees as defined by Tax 5. Company Structure Code, and therefore are ineligible Corporation ☐ S Corporation LLC to participate in the P.O.P. ☐ Sole Proprietorship Partnership Other: IMPORTANT: Read the information provided in the CaliforniaChoice<sup>®</sup> Employer □ Dental Other: 6. Premium payments may be elected for Medical Optional Benefits Guide pertaining to the Section 125 Premium Only Usually 12 months after the effective date of coverage; 7. Last day of first Plan year Plan and the tax consequences. subsequent plan years will be the 12 month period (If not indicated, last day of medical plan year will be used) (MM/DD/YYYY) following this date. J. SUPPRESS CONTRIBUTION † Suppressing contributions will result in only full premium amounts reflected on invoices and worksheets. Contribution must still be at least 50% of lowest cost plan for each employee. \*\*RENEWAL ONLY\*\* Changes below and on next page are only allowed at Renewal (Anniversary Date) K. CHANGE WAITING PERIOD TO FIRST DAY OF THE MONTH FOLLOWING ☐ Date of Hire ☐ 30 days ☐ 60 days (NOT to exceed 90 days) All employees currently in the waiting period must either enroll at Renewal or be subject to the previous waiting period. L. CHANGE HOURS OF ELIGIBILITY ☐ 20+ hours per week ☐ 30+ hours per week I understand and agree to the following: 1) Coverage must be extended to all employees working the number of hours per week considered to be eligible. 2) 70% of employees working the number of hours per week considered to be eligible must enroll. 3) Employer contribution for all employees must be the same. 4) Once the Hours of Eligibility change becomes effective, it must be maintained until our anniversary date. ■ M. CHANGE ORTHO ON DENTAL PLAN ☐ Add Ortho to current PPO Dental Coverage\* \*When adding Ortho coverage, please remember that there is a 12 month waiting period. Remove Ortho from current PPO Dental Coverage N. CHANGE METAL TIER **IMPORTANT:** Metal Tier change requests should be submitted Select **ONE** Metal Tier option to offer to your employees a minimum of 5 business days prior to your renewal date and **Total Choice** ■ BRONZE/SILVER/GOLD/PLATINUM include Change Request Forms for all enrollees. This will allow

Additional change options are located on next page

■ BRONZE/SILVER/GOLD
■ SILVER/GOLD/PLATINUM

☐ BRONZE ☐ SILVER ☐ GOLD ☐ PLATINUM

☐ BRONZE/SILVER ☐ SILVER/GOLD ☐ GOLD/PLATINUM

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time for processing and submission to the health plans.



**Triple Choice** 

**Double Choice** 

Single Choice

\*\*RENEWAL ONLY\*\* (cont.) Changes below are **only** allowed at Renewal (Anniversary Date) O. CHANGE PREMIUM CONTRIBUTION For medical contribution, please select Option 1, Option 2 or Option 3.  $^\dagger$ lf you wish to suppress contribution figures, please check Section J. **OPTION 1** PERCENTAGE OF COST (If requesting 100% contribution, you are attesting to meeting the requirement of 70% participation.) Dependent Premium STEP 1: Enter the percentage amount you will contribute toward Employee Premium % (write 0 if none) STEP 2: Apply contribution toward A\*, B\*, C\*, D, E, F, G, H\* or I (50% minimum) (\*If no HMO plan available to Employee, contribution will be based on lowest cost PPO plan) Lowest cost HMO within the Metal Tier(s) selected. **HMO** Anthem Cigna + Kaiser Sutter United Western & EPO **Blue Cross** Oscar Net Permanente Oscar Sharp **Health Plus** Healthcare Health Specific -☐ EPO A\* ☐ HMO A □ нмо в ☐ HMO A ☐ HMO A Health Plan ☐ EPO A\* □ ЕРО В ■ EPO A □ нмо в **BRONZE** ■ HMO A □ EPO B\* ☐ HMO B<sup>\*</sup> ☐ HMO C<sup>3</sup> ☐ HMO B\* (select one ☐ EPO C ☐ HMO C\* benefit plan from the ☐ HMO A ☐ HMO A ☐ HMO A ■ EPO A<sup>\*</sup> Metal ☐ HMO A □ нмо в ☐ HMO A □ НМО В ☐ HMO B ☐ EPO A ☐ EPO B □ нмо в ☐ HMO A Tier(s) SILVER □ нмо с □ нмо в ☐ HMO E ☐ HMO B ☐ EPO A selected □ ЕРО В □ нмо с ☐ EPO C ☐ HMO C ☐ HMO D\* □ нмо с ☐ HMO F ☐ HMO C\* in Section N) □ EPO B<sup>\*</sup> ☐ EPO D ☐ HMO E ☐ HMO G ☐ HMO A ☐ HMO A П нмо в ☐ EPO A ☐ HMO J ☐ HMO B ☐ HMO A ☐ HMO A □ нмо в □ нмо а ☐ HMO A ☐ EPO A □ нмо с П ЕРО В ☐ HMO E □ нмо к □ НМО В **GOLD** □ нмо с ☐ HMO B ☐ HMO B ☐ EPO B ☐ HMO D ☐ EPO C □ нмо в ☐ HMO F ☐ HMO L □ нмо с ☐ HMO D ☐ HMO D ☐ HMO E ☐ EPO D ☐ HMO G ☐ HMO M ☐ HMO D\* □ нмо н ☐ HMO F ☐ HMO N ☐ HMO C ☐ HMO A ☐ HMO H \*HSA Qualified ☐ HMO D □ нмо с ☐ HMO I ☐ HMO A ☐ HMO A High Deductible ☐ HMO A EPO A ☐ HMO E ☐ HMO A ☐ EPO A ☐ HMO D PLATINUM | HMO A Plan □ нмо в □ нмо в ☐ HMO E ■ EPO B ☐ HMO F ☐ EPO B □ НМО В ☐ HMO B □ нмо с □ нмо с ☐ HMO F ☐ HMO G □ нмо н ☐ HMO G **C.** □ HMO **SILVER GOLD PLATINUM BRONZE** Lowest cost benefit ☐ HMO A ☐ HMO G □ НМО М plan in HMO: (select ☐ HMO A ☐ HMO F ☐ HMO H ☐ HMO A ☐ HMO E ☐ HMO B ☐ HMO N □ НМО В ☐ HMO G one benefit level from ☐ HMO A □ нмо с ☐ HMO I ☐ HMO F □ нмо в the Metal Tier(s) **НМО** □ НМО С □ НМО Н ☐ HMO B ☐ HMO D ☐ HMO J ☐ HMO C ☐ HMO G selected in Section N) ☐ HMO D ☐ HMO I ☐ HMO C ☐ HMO E ☐ HMO K ☐ HMO D ☐ HMO E ☐ HMO F ☐ HMO L **D.** □ PPO **SILVER BRONZE GOLD** Specific Health Plan: ☐ PPO A\* PPO A ☐ PPO C ☐ PPO C ☐ PPO A ☐ PPO E (select one benefit plan from the Anthem Blue Cross PPO ☐ PPO B ☐ PPO B PPO D □ PPO B\* Metal Tier(s) selected in Section N) HSA Qualified High Deductible Plan E. PPO **BRONZE** SILVER **GOLD** Lowest cost benefit plan in PPO: ☐ PPO C PPO A\* ☐ PPO A ☐ PPO C ☐ PPO A ☐ PPO E (select one benefit level from the Anthem Blue Cross PPO □ РРО В □ PPO B\* ☐ PPO B PPO D Metal Tier(s) selected in Section N) \*HSA Qualified High Deductible Plan Lowest cost PPO within the Metal Tier(s) selected. F. □ G. Any HMO, EPO or PPO plan selected by employee. Lowest cost HMO/EPO from a specific Metal Tier (select one Metal Tier): ☐ Bronze ☐ Silver ☐ Gold Platinum ☐ Silver ☐ Gold Platinum Lowest cost PPO from a specific Metal Tier (select one Metal Tier): ☐ Bronze **EMPLOYER FIXED DOLLAR AMOUNT OPTION 2** Combined amount Enter the dollar amount(s) you for Dependents \$ for Employee will contribute toward any plan \$ OR for Employee (write 0 if none) and Dependents selected by the employee.

(CONTINUED ON NEXT PAGE)

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OPTION 3  EMPLOYEE FIXED DOLLAR AMOUNT											
STEP 1: Enter the dollar amount(s) the employee will contribute toward											
\$		Emplo	vee Cost	<b>\$</b>		Δ.	dditional for o	hild(ren)			
					Additional for child(ren)						
\$	do not make	Additional for Family  not make an additional contribution for dependents enter "NA"									
STEP 2: Apply contribution toward A or B											
A. HMO Anthem Cigna + Health Kaiser Sutter United Western											
— & EPO		Blue Cross	Oscar	Net	Permanente	Oscar	Sharp	Health Plus	Health		Health
Specific Health Plan (select one benefit plan from the Metal Tier(s) selected in Section N)	BRONZE	□ ЕРО А	☐ EPO A* ☐ EPO B*	□ нмо а	HMO A HMO B HMO C*	☐ EPO A* ☐ EPO B ☐ EPO C	☐ HMO A ☐ HMO B*	☐ HMO A ☐ HMO B*			☐ HMO B
	SILVER	HMO A HMO B EPO A EPO B*	□ EPO A □ EPO B	☐ HMO A ☐ HMO C	HMO A HMO B HMO C HMO D*	□ EPO A* □ EPO B □ EPO C □ EPO D	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO B	HMO A HMO B HMO E HMO F HMO G		HMO A HMO B HMO C*
*HSA Qualified High Deductible Plan	GOLD	☐ НМО А ☐ НМО В	□ EPO A □ EPO B	HMO A HMO B HMO C HMO D HMO D HMO E	☐ HMO B☐ HMO C☐ HMO D☐	□ EPO A □ EPO B □ EPO C □ EPO D	HMO A HMO B	□ НМО А □ НМО В	HMO A HMO B HMO E HMO F HMO G	HMO I HMO J HMO K HMO L HMO M HMO N	HMO A HMO B HMO C HMO D*
	PLATINUM	□ нмо а	☐ EPO A ☐ EPO B	HMO C HMO D HMO E HMO F HMO G	□ НМО А □ НМО В	□ ЕРО А □ ЕРО В	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	HMO A HMO C HMO D HMO E HMO F HMO G	☐ HMO H	☐ HMO A ☐ HMO B ☐ HMO C
B. ☐ PPO  BRONZE SILVER GOLD  Specific Health Plan: → PPO A ☐ PPO A ☐ PPO C ☐ PPO E ☐ PPO E											
Specific Health Plan: (select one benefit plan from the			PPO         □ PPO A*         □ PPO A         □ PPO C         □ PPO C         □ PPO D         □ PPO D					☐ PPO C ☐ PPO D	☐PPO E		
Metal Tier(s) selected in Section N)  *HSA Qualified High Deductible Plan											
OPTION 4   EMPLOYER DENTAL CONTRIBUTION											
Enter the percentage amount you will contribute  **More Employee (50% minimum required)  **More Dependents (write 0 if none)  **More Dependents (write 0 if none)  **More DHMO SmileSaver DHMO Ameritas PPO Dependents (write 0 if none)  **More DHMO											
Company Name Group#											
Authorized Gr	oun Contact	Signature			Print Name					ate (MM/DD/	VVVV

Log onto www.calchoice.com (Broker or Employer log-in) to download forms and brochures



(Person signing form must be authorized contact on record for CaliforniaChoice  $^{\circledR}$ )