CaliforniaChoice®
Your Health. Your Choice.®

721 South Parker, Suite 140, Orange, CA 92868
(800) 558-8003 • www.calchoice.com

Change Request Form

- **Do not use this form to change your physician or dentist**
- **Fax completed form to (714) 558-8000 or E-mail to: memberprocessing@calchoice.com**
- **PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING**

☐ **Check here if changes are to be effective at Renewal**
Complete steps A through E as applicable

A Complete Employee Information

Employee Last Name (Legal) | **Employee Social Security #**

Employee First Name (Legal) | **M.I.** | **Group #**

Check here if new address: ☐ Residential Address ☐ Mailing *(Address changes will be effective the 1st day of the month following the receipt of the request)*

Physical Address (Do not use P.O. Box) | **Apt. #** | **City**

State | **ZIP Code** | **County** | **Phone # (XXX) XXX-XXXX**

Company Name | **Employee E-mail Address**

☐ Name Change/Correction

New First Name (Legal) | **New M. I.**

New Last Name (Legal)

B Only Complete to Cancel Coverage or Add Dependents

Cancellations of coverage will take effect on the **last day** of the month **after receipt** of your request by CaliforniaChoice®. Cancellations at Renewal will take effect on the group's Renewal date.
Additions (qualifying/triggering event): Please refer to administrative handbook for effective date guidelines based on qualifying/triggering event.
Additions (at renewal): Coverage will be effective on the group's renewal date.
This form must be received by CaliforniaChoice **no later than 60 days** after the event takes place if outside renewal.

IF APPLICABLE: Date of marriage*/divorce if adding/cancelling spouse MM/DD/YYYY
**Attach copy of marriage license and/or certificate as applicable*

If child custody*, enter date of adoption MM/DD/YYYY
**Attach copy of legal documentation*

Reason for Cancellation

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
	Cancel	Add Cancel	Add Cancel	Add Cancel	Add Cancel
Coverage Type	Medical ☐ Dental ☐ Voluntary Vision ☐	Medical ☐ ☐ Dental ☐ ☐ Voluntary Vision ☐ ☐	Medical ☐ ☐ Dental ☐ ☐ Voluntary Vision ☐ ☐	Medical ☐ ☐ Dental ☐ ☐ Voluntary Vision ☐ ☐	Medical ☐ ☐ Dental ☐ ☐ Voluntary Vision ☐ ☐
Last Name (Legal)					
First Name (Legal)					
Social Security #		Social Security # required!	Social Security # required!	Social Security # required!	Social Security # required!
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Disabled?* *(Complete if over age 26)*			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*If you are enrolling a disabled dependent you must complete a Disabled Dependent Form. (Form can be found on the CaliforniaChoice website)

➡ To enroll more dependents, complete sections A & B on an additional Change Request Form.

IF ADDING DEPENDENT(S): By signing this document I declare under the penalty of perjury under the laws of the state of California that the following statements are true and correct regarding the enrolling dependents, as applicable:
My spouse and I are legally married as recognized by the state of California.
My children's dates of birth are accurate. My children are born to me or my spouse/domestic partner, or legally adopted, or a non-temporary legal ward, and/or have an established parent-child relationship with me or my spouse/domestic partner.
I understand that I may be asked for legal proof of the above at any time.
All statements and answers I have given are true and complete. **I understand** it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents.

(continued on next page)

PLEASE READ & SIGN THE BACK OF THIS FORM

Print Employee Name (Legal) _____ **Group #** _____

IF ADDING DEPENDENT(S) (continued)

If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and my right to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.

I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this statement may have cause to bring civil action against me to recover their losses.

The representations made are the basis upon which coverage may be issued. The coverage may be cancelled or the employer's contract rescinded because of the performance of an act or practice constituting fraud or making of an intentional misrepresentation of a material fact to an insurance company for the purposes of defrauding the company.

I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

IMPORTANT: Regarding Steps C and D, plan changes are only allowed at Renewal. However, employees who acquire a new dependent (i.e. newborn, new spouse etc.) are able to change their coverage outside of the Renewal Period.

C Only Complete to Add/Change your benefit plan

(CHECK ONE) ☐ **ADD** ☐ **CHANGE**

IMPORTANT: Please select ONE benefit plan from the metal tier(s) and plan options available to you on your CaliforniaChoice® Enrollment Worksheet.

HEALTH PLAN	BRONZE	SILVER	GOLD	PLATINUM
ANTHEM BLUE CROSS	☐ PPO A* ☐ PPO B* ☐ PPO C ☐ PPO D	☐ HMO A ☐ PPO B ☐ PPO F ☐ HMO B ☐ PPO C ☐ HMO D ☐ PPO D* ☐ PPO E*	☐ HMO A ☐ PPO B ☐ PPO H ☐ HMO B ☐ PPO C ☐ PPO I ☐ HMO C ☐ PPO D ☐ PPO E	☐ HMO A ☐ PPO B ☐ HMO B ☐ HMO C ☐ HMO D
HEALTH NET		☐ HMO A	☐ HMO A ☐ HMO D ☐ HMO H ☐ HMO B ☐ HMO E ☐ HMO I ☐ HMO C ☐ HMO G	☐ HMO C ☐ HMO E ☐ HMO J
KAISER PERMANENTE	☐ HMO A ☐ HMO C*	☐ HMO A ☐ HMO D* ☐ HMO B ☐ HMO E ☐ HMO C	☐ HMO B ☐ HMO E* ☐ HMO C ☐ HMO F ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C
SHARP	☐ HMO A ☐ HMO B*	☐ HMO A ☐ HMO C ☐ HMO B	☐ HMO A ☐ HMO D ☐ HMO B	☐ HMO A ☐ HMO C ☐ HMO B
SUTTER HEALTH PLAN	☐ HMO A ☐ HMO B*	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO C* ☐ HMO B	☐ HMO A
UNITED HEALTHCARE		☐ HMO A ☐ HMO E ☐ HMO F ☐ HMO G	☐ HMO A ☐ HMO E ☐ HMO J ☐ HMO B ☐ HMO F ☐ HMO L ☐ HMO C ☐ HMO G ☐ HMO M ☐ HMO D ☐ HMO H ☐ HMO N	☐ HMO A ☐ HMO G ☐ HMO N ☐ HMO B ☐ HMO H ☐ HMO C ☐ HMO I ☐ HMO E ☐ HMO M
WESTERN HEALTH ADVANTAGE	☐ HMO B ☐ HMO C*	☐ HMO B ☐ HMO D ☐ HMO C*	☐ HMO A ☐ HMO C ☐ HMO B ☐ HMO D*	☐ HMO B ☐ HMO D ☐ HMO C

*HSA Qualified High Deductible Plan

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
Last Name (Legal)					
First Name (Legal)					
Primary Care Physician**					
Current Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Provider ID#					
Provider City					

☐ Check here if you would like your Health Plan to assign you a Primary Care Physician.

** *If changing Health Plan, please select a Primary Care Physician (PCP). A PCP is not required for Kaiser Permanente and PPO benefit plans. If a PCP is not contracted with your selected Health Plan prior to enrolling or if a PCP is not listed, one will automatically be assigned to you. If remaining with the same Health Plan, but changing your benefit plan, please contact the Health Plan directly to confirm your PCP. For PCP changes only, please contact your Health Plan directly.*

(continued on next page)

Print Employee Name (Legal) _____ Group # _____

D Only Complete to Add/Change Optional Benefits

Dental Benefit Design Change/Add

(CHECK ONE) ☐ ADD ☐ CHANGE

MetLife DHMO† ☐ MET100 ☐ MET185 | **SmileSaver DHMO†** ☐ 1000 ☐ 3000 | **Ameritas PPO** ☐ 3000 ☐ 3500 ☐ 4000 ☐ 5000

† *MetLife and SmileSaver DHMO plans require selection of a family dentist. Upon receipt of dental ID cards, you may elect other dentists for dependents.*

Dentist's Name (If left blank or dentist unavailable, one will be assigned) _____ **ID#** _____ ☐ Check if current dentist ☐ Check if you would like a dentist assigned

Voluntary Vision Change/Add

(CHECK ONE) ☐ ADD ☐ CHANGE

☐ Voluntary EyeMed (provided by Ameritas)*

☐ Voluntary VSP (provided by Ameritas)*

*Employee is responsible for 100% of this cost if selected for coverage

Life Insurance Beneficiary Change

Complete only if you wish to change the existing beneficiary on your life insurance. This change will take effect on the date it was signed.

I hereby revoke any previous designation of beneficiary and settlement provisions and make the following beneficiary designation with respect to any insurance payable at my death under the group plan (including any Group Life Insurance or Group Accidental Death and Dismemberment Insurance)

Beneficiary Name(s)			Date of Birth	Relationship to You (i.e. spouse, friend, child)	*Percentage	*Type of Beneficiary
Last Name (Legal)	First Name (Legal)	M.I.				
			MM/DD/YYYY			☐ Primary ☐ Secondary
			MM/DD/YYYY			☐ Primary ☐ Secondary
			MM/DD/YYYY			☐ Primary ☐ Secondary

* If you are listing more than one primary beneficiary or more than one secondary beneficiary, please enter the percentage of the insurance proceeds that each individual should receive. The percentage of insurance proceeds must equal 100% for each type of beneficiary (primary or secondary). No secondary beneficiaries will be entitled to any part of the insurance proceeds if any primary beneficiary is living at the time of death of the insured. To list more beneficiaries, please submit an additional page and complete Section D.

E Your Legal Acknowledgement and Mandatory Binding Arbitration Agreement (Read, sign and date where indicated)

By submitting this signed application, I agree and understand that the health plan I have chosen through the CaliforniaChoice® program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the CaliforniaChoice program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize CaliforniaChoice and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

(continued on next page)

Print Employee Name (Legal) _____ Group # _____

E Your Legal Acknowledgement and Mandatory Binding Arbitration Agreement (Continued) (Read, sign and date where indicated)

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the employer named on this application, myself and my dependents named on this application.

- I am either actively, permanently working for the employer and considered eligible by my employer because I work either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem, 1099 or substitute employee or insured by or eligible to be insured by the employer's union policy.
- My children's dates of birth are accurate. My children are born to me or my spouse/domestic partner, or legally adopted, or a non-temporary legal ward, and/or have an established parent-child relationship with me or my spouse/domestic partner. **I understand** that I am required to notify CaliforniaChoice® when an established parent-child relationship ceases to exist.

I understand that the preceding statements are subject to audit at any time and **agree** to provide CaliforniaChoice with any and all information necessary to prove the above statements.

All statements and answers I have given are true and complete. I understand it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents. If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and my right to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance Code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.

I understand that any persons, business or health plan that suffers a loss because of false-declarations contained in this statement may take legal action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- The coverage may be cancelled or the employer's contract rescinded because of the performance of an act or practice constituting fraud or making of an intentional misrepresentation of a material fact to an insurance company for the purposes of defrauding the company.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

MANDATORY BINDING ARBITRATION

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the Health Plan's coverage document, which is available for my review.

Employee **SIGN HERE** ➡	**Print Name (Legal)**	**Today's Date (MM/DD/YYYY)**
		☐☐ / ☐☐ / ☐☐☐☐

My signature acknowledges that I have read Section E, the applicable mandatory binding arbitration of the plan I selected in Section C and my decision to enroll in the medical, dental, life or vision coverage that I selected in Sections C and D.

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met
New Spouse/ New Stepchild	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Spouse can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a spouse will require a state-stamped copy of the Marriage Certificate. If the married parties have not yet received the state-stamped copy of the Marriage Certificate, a county issued receipt displaying the names of the parties and the date of marriage may be acceptable. Married parties agree to provide a copy of the state-stamped Marriage Certificate within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the marriage was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month, coverage begins on the 1st of the month following the date of receipt.	■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
Birth/Adoption/ Legal Guardianship/ Eligible Dependent Child	If birth/date of placement occurred before the 16th of the month, coverage begins on the first day of the month of the date of birth/placement. If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the following month. Coverage for the dependent begins on the first of the month following the birth/date of placement.	**MEDICAL, CHIRO, VISION and METLIFE & SMILESAVER DENTAL** Dependent eligibility: ■ Born to, a stepchild or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **AMERITAS DENTAL** Dependent eligibility: ■ Born to, a stepchild or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **Disabled Dependents:** Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner/ Child of Domestic Partner	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a domestic partner will require a state-stamped copy of the Declaration of Domestic Partnership from the California Secretary of State within 60 days of issuance. If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted.Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month, coverage begins on the 1st of the month following the date of receipt.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to CaliforniaChoice® within 60 days of its issue. For out-of-state domestic partners, please complete the Affidavit of Domestic Partnership. ■ Agree to notify CaliforniaChoice immediately upon termination of domestic partnership. Children of Domestic Partner must also meet the dependent children requirements listed above **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**

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