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

Employer Change Request Form

E-mail: gpc@choiceadmin.com

PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING.

Company Name

Group #

☐ A. CHANGE ADDRESS/PHONE/FAX

Please list the group's new billing address below: (☐ Check here if billing address and street address are the same)

Group's new **billing** address

Street

City

County

State

ZIP Code

Group's new **street** address

Street

City

County

State

ZIP Code

☐ Check here if phone and/or fax # has not changed

New phone and/or fax #

Phone # (XXX) XXX-XXXX

Fax # (XXX) XXX-XXXX

☐ 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

Extension #

E-mail Address

Additional Contact

Title/Position

Direct Phone # (XXX) XXX-XXXX

Extension #

E-mail Address

Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:

Remove Contact

Remove Contact

☐ C. CHANGE PAY PERIOD

Select the number of pay periods (Will be shown on Employee Enrollment Worksheets)

☐ 12 ☐ 24 ☐ 26 ☐ 48 ☐ 52

☐ D. 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.

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, C, & D completed.
2. A reconciled quarterly/annual wage report must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, S=seasonal, etc.)
3. 100% employer-paid premiums

Guaranteed Issue Amounts

Eligible Employees	Minimum	Maximum
1-5	$5,000	$5,000
6-10	$5,000	$10,000
11-25	$5,000	$25,000
26-100	$5,000	$50,000

Select a Flat amount for all employees

Amount $

# of eligible employees

▼▼▼▼ *CHIROPRACTIC/ACUPUNCTURE, DENTAL AND VISION CHANGES MAY ONLY BE MADE ONCE A YEAR* ▼▼▼▼

☐ E. ADD CHIRO*PLUS*

☐ 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)

F. ADD DENTAL

***Complete the Dental Application (Form # CC 0566)**

G. ADD VOLUNTARY VISION

***Complete the Voluntary Vision Application (Form # CC 0285)**

☐ H. ADD SECTION 125*

1. Name of Company President, Principal, or Partners

2. Name of Corporate Secretary (if applicable)

3. Plan # ____ (usually 501)
(If not indicated, 501 will be used)

4. State of Incorporation ____
(if applicable)

5. Company Structure

☐ Corporation ☐ S Corporation ☐ LLC
☐ Sole Proprietorship ☐ Partnership ☐ Other: ____

6. Premium payments may be elected for ☐ Medical ☐ Dental ☐ Other: ____

7. Last day of first Plan year ____ (MM/DD/YYYY)
(If not indicated, last day of medical plan year will be used)

Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.

Participation Limitations: 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 Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore are ineligible to participate in the P.O.P.

IMPORTANT: Read the information provided in the CaliforniaChoice® Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

☐ I. SUPPRESS/UNSUPPRESS CONTRIBUTION

☐ Suppress† ☐ Unsuppress

† 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)

☐ J. 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.

☐ K. 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.

☐ L. CHANGE ORTHO ON DENTAL PLAN

☐ Add Ortho to current PPO Dental Coverage*

☐ Remove Ortho from current PPO Dental Coverage

*When adding Ortho coverage, please remember that there is a 12 month waiting period.

☐ M. CHANGE METAL TIER

Select **ONE** Metal Tier option to offer to your employees

Total Choice	☐ BRONZE/SILVER/GOLD/PLATINUM
Triple Choice	☐ BRONZE/SILVER/GOLD ☐ SILVER/GOLD/PLATINUM
Double Choice	☐ BRONZE/SILVER ☐ SILVER/GOLD ☐ GOLD/PLATINUM
Single Choice	☐ BRONZE ☐ SILVER ☐ GOLD ☐ PLATINUM

IMPORTANT: Metal Tier change requests should be submitted **a minimum of 5 business days prior** to your renewal date and include Change Request Forms for all enrollees. This will allow time for processing and submission to the health plans.

Additional change options are located on next page

☐ N. CHANGE MEDICAL PREMIUM CONTRIBUTION FOR EACH MONTH — CHOOSE ONLY ONE OPTION BELOW

Your minimum contribution must be at least 50% of the "Employee only" monthly premium for the lowest priced medical plan offered by you, the Employer. † If you wish to suppress contribution figures, please check Section I.

☐ OPTION 1 — PERCENTAGE OF COST

○ Tier ________ Health Plan ________ Benefit Level ________ **OR** ○ All Plans **OR** ○ Lowest Cost Plan

Employee Premium [ ] %
(50% minimum for employee)

Dependent Premium [ ] %
(optional)

☐ OPTION 2 — FIXED DOLLAR OF COST (ANY PLAN SELECTED)

Employee Premium $ [ ]

Dependent Premium $ [ ]
(optional)

☐ O. CHANGE EMPLOYER SPONSORED DENTAL PREMIUM CONTRIBUTION FOR EACH MONTH

Your minimum contribution must be at least 50% of the "Employee only" monthly premium for the lowest priced dental plan offered by you, the Employer. † If you wish to suppress contribution figures, please check Section I.

Employee Premium [ ] %
(50% minimum for employee)

Dependent Premium [ ] %
(optional)

Applied toward (check one box only)

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

Company Name	**Group #**

______________________________ ______________________________ ______________________________

Authorized Group Contact Signature **Print Name** **Date (MM/DD/YYYY)**

(Person signing form must be authorized contact on record for CaliforniaChoice® *)*

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