



Change Request Form

- **EMPLOYEES: USE THIS FORM TO UPDATE PERSONAL INFORMATION OR TO ADD/CANCEL COVERAGE**
- **DO NOT USE THIS FORM TO CHANGE PHYSICIAN OR DENTIST**
- **PLEASE RETURN COMPLETED FORM TO HEALTH PLAN ADMINISTRATOR**

1 Employee Information

PLEASE PRINT USING BLACK OR BLUE INK

Employee Last Name												Employee Social Security Number							
Employee First Name												Middle Initial		CaliforniaChoice® Group #					

EMPLOYER/COMPANY NAME

2 Name/Address Change

COMPLETE THIS SECTION ONLY IF REPORTING A NAME/ADDRESS CHANGE

TYPE OF CHANGE: NAME ADDRESS If your address has changed (including a zip code change), request a worksheet to ensure participating carriers are available and complete a new enrollment application and attach to this form.

LAST NAME	FIRST	MIDDLE INITIAL	HOME TELEPHONE ()
ADDRESS	CITY	STATE	ZIP CODE

3 Coverage Change

Complete only if you are an active employee who wants to add or cancel coverage

THIS FORM MUST BE RECEIVED BY CALIFORNIA CHOICE® BENEFIT ADMINISTRATORS NO LATER THAN 31 DAYS AFTER THE EVENT TAKES PLACE IN ORDER TO QUALIFY FOR COVERAGE.

Cancellations of coverage will take effect on the **last day** of the month **after receipt** of your request by CaliforniaChoice® Benefit Administrators.
Additions: coverage (due to a qualifying event that took place between the 1st and 15th of the month) will be effective on **the date of the qualifying event.**
Additions: coverage (due to a qualifying event that took place between the 16th and the end of the month) will be effective on the **1st day** of the month **following event** (marriage, domestic partnership, birth, adoption/legal ward).

Those selecting dependent coverage for both medical and dental must enroll the same dependents. (if selecting employee only medical, any dental dependent coverage is acceptable. If selecting employee only dental, any medical dependent coverage is acceptable)

IF APPLICABLE: Date of marriage/divorce if adding/cancelling spouse: If child custody, enter date of adoption: Reason for Cancellation:

**Attach copy of court documentation, marriage license and/or certificate as applicable* **Attach copy of legal documentation*

Coverage Type	Last Name	First Name	Social Security Number	Birth Date (Month/Day/Year)	Full Time Student?	Dependent Disabled?	MEDICAL ONLY Primary Care Physician ID #	✓ below if current doctor
EMPLOYEE <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision <input type="checkbox"/> Cancel			— —	/ /				
<input type="checkbox"/> Spouse OR <input type="checkbox"/> Domestic Partner ↓ <input type="checkbox"/> Add* <input type="checkbox"/> Cancel		<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /				
CHILDREN <input type="checkbox"/> Add* <input type="checkbox"/> Cancel		<input type="checkbox"/> Son <input type="checkbox"/> Daught.	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Add* <input type="checkbox"/> Cancel		<input type="checkbox"/> Son <input type="checkbox"/> Daught.	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Add* <input type="checkbox"/> Cancel		<input type="checkbox"/> Son <input type="checkbox"/> Daught.	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

NOTE: If Last Name of spouse/child(ren) is different from Employee's Last Name, please give brief explanation:

***As I am adding my dependent(s), and 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 above 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: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.
 I **understand** that I may be asked for legal proof of the above at any time.
 I **understand** that false statements and/or failure to provide the information upon request will cause the termination of all CaliforniaChoice® benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through CaliforniaChoice® program providers thereafter.
 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. If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
 I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements.

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met:
<p>New Spouse/ New Stepchild</p>	<p>If marriage occurred before the 16th of the month, coverage begins on date of marriage[†]</p> <p>If marriage occurred on the 16th of the month or after, coverage begins on the first of month <u>following</u> date of marriage</p>	<ul style="list-style-type: none"> ■ New spouse must be legally married to the employee
<p>New Baby, Adopted Child, Non-Temporary Legal Ward, and Dependent Children</p>	<p>If birth/date of placement occurred before the 16th of the month, coverage begins on the date of their birth/placement[†]</p> <p>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 <u>following</u> month</p>	<ul style="list-style-type: none"> ■ Born to, a step-child of, adopted by, or non-temporary legal ward of the Employee ■ Financially Dependent upon the Employee per IRS guidelines ■ Unmarried ■ Under age 19—unless disabled, disability occurring prior to age 25—or a full time student and under age 25 <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a 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, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
<p>Domestic Partner</p>	<p><u>During Initial Enrollment or Group's Annual Renewal:</u> Coverage begins on group's effective date</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a Domestic Partner will require a State stamped copy of the Certificate of Registered Domestic Partnership within 30 days of issue or a signed affidavit for opposite sex, and under age 62 domestic partnerships.</p>	<p><u>For a Domestic Partner to qualify, Employee and Domestic Partner must:</u></p> <ul style="list-style-type: none"> ■ Share a common residence ■ Neither is married under either statutory, common law or part of another domestic partnership ■ Both be 18 years of age or older ■ Share an intimate and committed relationship ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify CaliforniaChoice[®] immediately upon termination of domestic partnership <p>Members who are in a same sex partnership or are over the age of 62 are required to submit a Certificate of Registration of Domestic Partnership. All others must submit a signed Domestic Partner Affidavit.</p> <p style="text-align: center;">Employee and Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
<p>Children of Domestic Partner</p>	<p>See Domestic Partner above</p>	<p><u>Domestic Partner must meet requirements listed above, and Children of Domestic Partner must be:</u></p> <ul style="list-style-type: none"> ■ Born to, a step-child of, adopted by, or non-temporary legal ward of the Employee or Domestic Partner ■ Financially Dependent upon the Employee or Domestic Partner ■ Unmarried ■ Under age 19—unless disabled, disability occurring prior to age 25—or a full time student and under age 25 <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a 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, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>

[†] Although coverage may become effective at any time of the month based on date of marriage/domestic partnership/birth/adoption, full premium for increased coverage will be assessed as described in the Effective Dates column located above.

4 Life Insurance Beneficiary Change

COMPLETE ONLY IF YOU WISH TO CHANGE THE EXISTING BENEFICIARY ON YOUR LIFE INSURANCE

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 (Mo/Day/Yr)	Relationship to You (i.e. spouse, friend, child)	*Percentage	Primary or †Secondary
Last Name	First Name	M.I.				
			/ /			
			/ /			
			/ /			
			/ /			

*If you are listing more than one Beneficiary or Contingent Beneficiary, please enter the percentage of the proceeds that each individual should receive.

Unless otherwise provided, if more than one primary beneficiary is designated, the primary beneficiary or primary beneficiaries living at the death of the employee shall be entitled to the insurance, equally if more than one. †However, if the designation provides for primary and secondary beneficiaries, no secondary beneficiary or secondary beneficiaries shall be entitled to any part of such insurance if any primary beneficiary is living at the death of the employee.

If there is no designated beneficiary living at the death of the employee, the insurance will be paid in accordance with the terms of the plan.

The right to change this designation is reserved to the employee under the terms of the plan.

SPOUSE SIGNATURE
(Required if beneficiary is someone other than spouse)

DATE

NOTE: This change will be considered to become effective on the day it is received by CaliforniaChoice®.

Your LEGAL Acknowledgement (Read, Sign & Date Below)

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 for 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.

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 or a 1099 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: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.

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

I understand that false statements and/or failure to provide the information upon request will cause the termination of all CaliforniaChoice® benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through CaliforniaChoice® program providers thereafter.

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.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements listed on the second page of this application.

Employee SIGN HERE:

Date:



CALIFORNIACHOICE® STAFF USE BELOW THIS POINT

PLAN CODE

PROCESSED

EMPLOYEE #

EFFECTIVE DATE