Small Business Health Options Program (SHOP)
Change Request Form for Employees

COVERED CALIFORNIA

☐ Check here if changes are to be effective at renewal.

Fax completed form to (949) 809-3264 or
mail to SHOP at P.O. Box 7010, Newport Beach, CA 92658
For assistance call (877) 453-9198

EMPLOYER INFORMATION

Employer name & address

Employer phone number ( ) -	SHOP CASE ID #

REASON FOR CHANGE (CHECK ALL THAT APPLY)

		EFFECTIVE DATE MM/DD/YYYY
☐ GROUP OPEN ENROLLMENT		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐ NEW HIRE	INDICATE DATE COVERAGE WILL BE EFFECTIVE	
☐ PART-TIME TO FULL-TIME EMPLOYMENT CHANGE	INDICATE DATE COVERAGE WILL BE EFFECTIVE	
☐ LOSS OR GAIN OF OTHER COVERAGE	INDICATE DATE OF EFFECTIVE CHANGE AND PROVIDE LETTER FROM CARRIER OR EMPLOYER	
☐ NAME CHANGE/ADDRESS CHANGE	INDICATE EFFECTIVE DATE OF CHANGE	
☐ MARRIAGE OR DOMESTIC PARTNER ADDITION	INDICATE DATE OF MARRIAGE OR DOMESTIC PARTNER DECLARATION	
☐ BIRTH, ADOPTION OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) OF DEPENDENT CHILD	INDICATE DATE OF BIRTH, ADOPTION OR QUALIFIED MEDICAL CHILD SUPPORT ORDER	
☐ OTHER, PLEASE DESCRIBE:		

PLEASE PROVIDE THE DETAIL REGARDING YOUR CHANGE(S) IN THE RESPECTIVE SECTIONS THAT FOLLOW.

EMPLOYEE INFORMATION

1. First name, Middle name, Last name & Suffix

2. Social Security Number or Tax ID Number	Sex

NEW EMPLOYEE Complete information below. **EXISTING EMPLOYEE** Complete only information that has changed.

3. HOME address			4. Apartment or suite number
5. City	6. State	7. ZIP code	8. County
9. MAILING address			10. Apartment or suite number
11. City	12. State	13. ZIP code	14. County

15. Email address (OPTIONAL)	16. Phone number ☐ Cell ☐ Home ☐ Work ( ) -	17. Other phone number ☐ Cell ☐ Home ☐ Work ( ) -

18. What is the preferred method of communication? ☐ Mail ☐ Email ☐ Phone

☐ **CHECK HERE IF NAME CHANGE OR CORRECTION**

19. New First Name

20. New Last Name

NEED HELP WITH YOUR FORM? Contact your employer or your employer's Covered California Certified Insurance Agent with questions, visit **CoveredCA.com** or call us at (877) 453-9198. Para obtener una copia de este formulario en Español, llame (877) 453-9198.

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Employee name	Employer Name	SHOP Case ID#

COMPLETE THIS SECTION TO CANCEL COVERAGE, ADD DEPENDENTS OR CHANGE PLANS

IMPORTANT! Plan changes are only allowed at renewal. However, employees who experience a qualifying event (i.e. acquire a new dependent) are able to change their coverage outside of the renewal period.

- **CANCELLATIONS** of coverage will take effect on the **LAST DAY** of the month **AFTER RECEIPT** of your request by Covered California. Cancellations at renewal will take effect on the group's renewal date.
- **ADDITIONS (QUALIFYING EVENT):** Please see your employer for effective date guidelines based on qualifying event.
- **ADDITIONS (AT RENEWAL):** Coverage will be effective on the group's renewal date.

This form must be received by Covered California **NO LATER THAN 60 DAYS** after the event takes place if outside renewal.

EMPLOYEE

LAST NAME (FAMILY NAME)	FIRST NAME	MI	SSN / TAX ID #	SEX

BIRTHDATE MM/DD/YYYY	NAME OF HEALTH PLAN SELECTED
☐ ADD ☐ CHANGE ☐ CANCEL	NAME OF DENTAL PLAN SELECTED (OPTIONAL)

Please see the following page for the available SHOP health and dental plans to choose from.

REASON	LAST DAY OF COVERAGE

SPOUSE OR DOMESTIC PARTNER

LAST NAME (FAMILY NAME)	FIRST NAME	MI	SSN / TAX ID #	SEX

BIRTHDATE MM/DD/YYYY	ARE YOU A DOMESTIC PARTNER? ☐ YES ☐ NO	IF YES, IS THE PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? ☐ YES ☐ NO	DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL	REASON	LAST DAY OF COVERAGE

CHILD

LAST NAME (FAMILY NAME)	FIRST NAME	MI	SSN / TAX ID #	SEX

BIRTHDATE MM/DD/YYYY	IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER? ☐ YES ☐ NO	DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL	REASON	LAST DAY OF COVERAGE

ADDRESS (IF DIFFERENT THAN EMPLOYEE)	STREET	CITY	STATE	ZIP

CHILD

LAST NAME (FAMILY NAME)	FIRST NAME	MI	SSN / TAX ID #	SEX

BIRTHDATE MM/DD/YYYY	IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER? ☐ YES ☐ NO	DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL	REASON	LAST DAY OF COVERAGE

ADDRESS (IF DIFFERENT THAN EMPLOYEE)	STREET	CITY	STATE	ZIP

CHILD

LAST NAME (FAMILY NAME)	FIRST NAME	MI	SSN / TAX ID #	SEX

BIRTHDATE MM/DD/YYYY	IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER? ☐ YES ☐ NO	DENTAL PLAN SELECTED

☐ ADD ☐ CHANGE ☐ CANCEL	REASON	LAST DAY OF COVERAGE

ADDRESS (IF DIFFERENT THAN EMPLOYEE)	STREET	CITY	STATE	ZIP

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NEW HEALTH AND DENTAL PLAN CHOICES

IMPORTANT! Plan changes are only allowed at renewal. However, employees who experience a qualifying event (e.g. acquire a new dependent) are able to change their coverage outside of the renewal period.

Not all health plans featured may be available. Please check with your employer for the list of available health plans in your area.

Health Plan	METAL TIER			
	Bronze	**Silver**	**Gold**	**Platinum**
Blue Shield	❍ Bronze 60 PPO	❍ Silver 70 HMO	❍ Gold 80 HMO	❍ Platinum 90 HMO
Chinese Community Health Plan	❍ Bronze 60 HMO w/Child Dental	❍ Silver 70 HMO w/Child Dental	❍ Gold 80 HMO w/Child Dental	❍ Platinum 90 HMO w/ Child Dental
Health Net	❍ Bronze 60 PPO	❍ Silver 70 PPO ❍ Silver 70 HSA EPO Alternate	❍ Gold 80 PPO ❍ Gold 80 EPO Alternate	❍ Platinum 90 PPO
Kaiser Permanente	❍ Bronze 60 HSA HMO ❍ Bronze 60 HMO	❍ Silver 70 HSA HMO ❍ Silver 70 HMO ❍ Silver 70 HMO Alternate	❍ Gold 80 HMO ❍ Gold 80 HMO Alternate	❍ Platinum 90 HMO
Sharp	❍ Bronze 60 HMO Network 2 w/ Child Dental (coinsurance) ❍ Bronze 60 HSA HMO Network 1 w/Child Dental (coinsurance)	❍ Silver 70 HMO Network 1 w/Child Dental (copay) ❍ Silver 70 HMO Network 2 w/Child Dental (coinsurance) ❍ Silver 70 HSA HMO Network 1 w/Child Dental (coinsurance)	❍ Gold 80 HMO Network 1 w/Child Dental (copay) ❍ Gold 80 HMO Network 2 w/Child Dental (coinsurance)	❍ Platinum 90 HMO Network 1 w/Child Dental (copay) ❍ Platinum 90 HMO Network 2 w/Child Dental (coinsurance)
Western Health Advantage	❍ Bronze 60 HMO w/Child Dental ❍ Bronze 60 HSA HMO Alternate w/Child Dental	❍ Silver 70 HMO w/Child Dental ❍ Silver 70 HSA HMO w/Child Dental	❍ Gold 80 HMO w/Child Dental	❍ Platinum 90 HMO w/ Child Dental

Dental Plans	PEDIATRIC DENTAL PLANS	FAMILY DENTAL PLANS**
Access Dental	❍ Children's Dental HMO	❍ Family Dental HMO
Blue Shield	❍ Children's Dental HMO ❍ Children's Dental PPO	Not available
Delta Dental	❍ Children's Dental HMO ❍ Children's Dental PPO	❍ Family Dental HMO ❍ Family Dental PPO
Guardian	❍ Children's Dental PPO	❍ Familiy Dental PPO
Liberty Dental	❍ Children's Dental HMO	❍ Family Dental HMO
Managed Dental Care	❍ Children's Dental HMO	❍ Family Dental HMO
MetLife	❍ Children's Dental PPO	Not available
SafeGuard	❍ Children's Dental HMO	❍ Family Dental HMO
Dental Health Services	❍ Children's Dental HMO	❍ Family Dental HMO

** Family dental plans offer both adult only and adult plus child coverage. Note, however, that if one child is enrolled in the Family Dental coverage, all children must enroll.

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SIGN THE FORM

COVERED CALIFORNIA ARBITRATION AGREEMENT

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.

I am signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Signature of Employee	Date (mm/dd/yyyy)
Employer Name	

RETURN YOUR COMPLETED, SIGNED FORM TO YOUR EMPLOYER

Your employer will send us your form, and we will contact you if we need additional information or to let you know your request for changes to your coverage have been approved.

CERTIFIED INSURANCE AGENT INFORMATION

Please tell us the Certified Insurance Agent who assisted you with your SHOP health insurance coverage.

Certified Insurance Agent Name	Email	Phone Number

☐ **I did not receive assistance from a Certified Insurance Agent.**

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