CaliforniaChoice®

Your Health. Your Choice.®

www.calchoice.com

Change Request Form

- **EMPLOYEES: COMPLETE THIS FORM ONLY IF YOU ARE AN ACTIVE CALIFORNIA*CHOICE*® MEMBER WHO WANTS TO UPDATE PERSONAL INFORMATION, ADD/CANCEL COVERAGE DEPENDENTS OR VOLUNTARILY CANCEL COVERAGE**
- **DO NOT USE THIS FORM TO CHANGE YOUR PHYSICIAN OR DENTIST**
- **PLEASE RETURN COMPLETED FORM TO HEALTH PLAN ADMINISTRATOR**
- **EMPLOYER: FAX COMPLETED FORM TO (714) 558-8000**

1 Employee Information

Please print using black or blue ink

Employee Last Name	Employee Social Security Number

Employee First Name	Middle Initial	California*Choice* Group #

EMPLOYER/COMPANY NAME

2 Name/Address Change

Complete this section only if reporting a name/address change

TYPE OF CHANGE: ❑ **NAME** ❑ **ADDRESS** (IF ADDRESS CHANGE **REQUIRES** A PLAN CHANGE, PLEASE COMPLETE A NEW ENROLLMENT APPLICATION AND ATTACH TO THIS FORM.)

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

NEW ADDRESS LISTED IS: ❑ **RESIDENTIAL ADDRESS** ❑ **MAILING ADDRESS**

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* NO LATER THAN 31 DAYS AFTER THE EVENT TAKES PLACE IN ORDER TO QUALIFY FOR COVERAGE.

Dependent enrollment must be the same for all lines of coverage for medical and dental (except for voluntary dental).

IF APPLICABLE: Date of marriage/divorce if adding/cancelling spouse: ______ **Attach copy of court documentation, marriage license and/or certificate as applicable*

If child custody, enter date of adoption: ______ **Attach copy of legal documentation*

Reason for Cancellation: ______

	Coverage Type	Last Name	First Name	Social Security Number	Birth Date (Month/Day/Year)	Full Time Student?	Dependent Disabled?	MEDICAL ONLY Primary Care Physician Name	ID #	✓ below if current doctor
EMPLOYEE ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision			— —	/ /			To change your physician or dentist, please contact your carrier. Refer to your handbook for carrier information.		
❑ Spouse OR ❑ Domestic Partner ❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Male ❑ Female	— —	/ /					
CHILDREN ❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Son ❑ Daught.	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No			
CHILDREN ❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Son ❑ Daught.	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No			
CHILDREN ❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Son ❑ Daught.	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ 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 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 California*Choice* benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through California*Choice* 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 I myself and my dependents have met all of the eligibility requirements.

PLEASE READ & SIGN THE BACK OF THIS FORM!

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.

This change will take effect on the date it was signed.

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 California*Choice*® 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 California*Choice* 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 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 California*Choice* 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 California*Choice* benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through California*Choice* 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 I myself and my dependents have met all of the eligibility requirements listed on the third page of this application.

Employee **SIGN HERE:** Date:

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse/ New Stepchild	If marriage occurred before the 16th of the month, coverage begins on the first day of the month of the date of marriage. If marriage occurred on the 16th of the month or after, coverage begins on the first of month following date of marriage.	■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
New Baby, Adopted Child, Non-Temporary Legal Ward, and Dependent Children	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.	■ Born to, a stepchild or legal ward of, or adopted by 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 19 (unless disabled, disability diagnosed prior to age 19) or a full-time student until the student's 25th birthday. A full-time student is one taking at least 12 semester units (or equivalent hours) in a qualified college, university or vocational school. 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**
EFFECTIVE 10/1/10 for new groups and groups as they come up for Renewal New Baby, Adopted Child, Non-Temporary Legal Ward, and Dependent Children	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 **SMILESAVER** DENTAL Dependent eligibility: ■ Born to, a stepchild or legal ward of, or adopted by 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, or adopted by 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 19 (unless disabled, disability diagnosed prior to age 19) or a full-time student until the student's 25th birthday. A full-time student is one taking at least 12 semester units (or equivalent hours) in a qualified college, university or vocational school. 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 Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnerships. If domestic partnership established before the 16th of the month, coverage begins on the first day of the month of the date of event. If domestic partnership established on the 16th of the month or after, coverage begins on the first of month following date of event.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ 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 California*Choice*® immediately upon termination of domestic partnership Children of Domestic Partner must also meet the dependent children requirements listed above Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership. **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**

CC 0500B 3/2011