CaliforniaChoice®
Your Health. Your Choice.®

www.calchoice.com

Change Request Form

- Use blue or black ink pen
- Do not shrink this form
- Do not use this form to change your physician or dentist
- Fax completed form to (714) 558-8000 or email to: memberprocessing@calchoice.com
- For assistance call (800) 558-8003

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

A Complete Employee Information

Employee Last Name | **Employee Social Security Number**

Employee First Name | **Middle Initial** | **CaliforniaChoice® 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 for residential address) | **Apt. #** | **City**

State | **Zip Code** | **County** | **Home Telephone** ( ) | **Company Name**

☐ Name Change/Correction: **New First Name**

New Last Name

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 California*Choice*. Cancellations at Renewal will take effect on the group's Renewal date.
Additions (qualifying event): Please refer to administrative handbook 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 California*Choice* **no later than 60 days** after the event takes place if outside renewal.

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

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

	Employee	Spouse/Domestic Partner	Child	Child	Child
	❑ 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					
First Name					
Social Security No.		Social Security # required!	Social Security # required!	Social Security # required!	Social Security # required!
Gender		❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Date of Birth		/ /	/ /	/ /	/ /
Disabled?			❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Primary Care Physician*					
Current Patient?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Physician ID#					
Physician City					

❑ Check here if you would like your Health Plan to assign you a Primary Care Physician.
➡ To enroll more dependents, complete sections A & B on an additional Change Request Form.

* *If changing health plans or adding a plan, please select a Primary Care Physician. A Primary Care Physician (PCP) is not required for Kaiser Permanente, EPO 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. For PCP changes only, please contact your Health Plan directly.*

PLEASE READ & SIGN THE BACK OF THIS FORM!

CC 0500 12/2013

Employee Name _____ **Group Number** _____

IF ADDING DEPENDENT(S) ON PAGE 1: 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 listed on page 1, 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.

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.

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) shown on your Enrollment Worksheet.

HMO / EPO / PPO

HEALTH PLAN	BRONZE	SILVER	GOLD	PLATINUM
AETNA	☐ HMO A	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B	☐ HMO A
ANTHEM BLUE CROSS	☐ EPO A	☐ HMO A ☐ EPO A ☐ PPO A ☐ PPO B	☐ HMO A ☐ HMO B ☐ PPO A ☐ PPO B ☐ PPO C ☐ PPO D	☐ HMO A
HEALTH NET	☐ PPO A	☐ PPO A	☐ HMO A ☐ HMO B ☐ PPO A	☐ HMO A
KAISER PERMANENTE	☐ HMO A* ☐ HMO B ☐ HMO C*	☐ HMO A* ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A
SHARP	☐ HMO A ☐ HMO B*	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B
WESTERN HEALTH ADVANTAGE	☐ HMO A*	☐ HMO A	☐ HMO A	☐ HMO A

*HSA Qualified High Deductible Plan

D Only Complete to Add/Change Optional Benefits

Dental Benefit Design Change/Add

(CHECK ONE) ❑ **ADD** ❑ **CHANGE**

❑ FDH 100
❑ Prepaid 1000†
❑ Prepaid 3000†
❑ Voluntary Prepaid 3000†
❑ EPO 3000
❑ EPO 3500
❑ PPO 4000
❑ PPO 5000

† *If electing any plan above, please select a dentist*

Dentist's Name (If left blank or dentist unavailable, one will be assigned) ID #

❑ Check if current dentist

Voluntary Vision Add

❑ Check this box to add Voluntary Vision (at additional cost)

(continued on next page)

Employee Name _____ Group Number _____

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 (Mo/Day/Yr)	Relationship to You (i.e. spouse, friend, child)	*Percentage	*Type of Beneficiary
Last Name	First Name	M.I.				
			/ /			❑ Primary ❑ Contingent
			/ /			❑ Primary ❑ Contingent
			/ /			❑ Primary ❑ Contingent

* If you are listing more than one primary beneficiary or more than one contingent 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 contingent). No contingent 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.

E Complete Your Legal Acknowledgement - Read, Sign and Date Where Indicated

By submitting this signed application, I agree and understand that the health plan I have chosen through the California*Choice*® 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 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 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.

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 California*Choice* when an established parent-child relationship ceases to exist.

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 page 5 of this application.

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

(continued on next page)

E *(Continued)* Complete Your Legal Acknowledgement - Read, Sign and Date Where Indicated

AETNA ENROLLEES:
Notice of Binding Arbitration:
Any dispute arising from or related to Health Plan Membership will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California Law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by this agreement were unnecessary or were unauthorized or were improperly, negligently or incompetently rendered. The health plan agreement also limits certain remedies and may limit the award of punitive damages. See the Evidence of Coverage for further information. I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.

ANTHEM BLUE CROSS ENROLLEES:
I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision.

The following provision does not apply to class actions:
IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

HEALTH NET ENROLLEES:
BINDING ARBITRATION AGREEMENT:
Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

KAISER FOUNDATION HEALTH PLAN ENROLLEES:
Arbitration Agreement:
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), 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 KFHP, 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 contained in the *Evidence of Coverage*.

SHARP ENROLLEES:
It is understood that any dispute or controversy between the Member and the Plan arising out of or in connection with this Group Agreement, excluding a claim of medical malpractice, will be determined by submission to final and binding arbitration in accordance with the provisions of Article XIII of this Group Agreement, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Group Agreement, by entering into it, are giving up their constitutional right to have any such dispute or controversy decided in a court of law before a jury, and instead are accepting the use of arbitration.

WESTERN HEALTH ADVANTAGE ENROLLEES:
Arbitration Agreement:
I agree and understand that any and all disputes between myself (including any heirs or assigns) and Western Health Advantage, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. The parties, including any heirs or assigns, to this arbitration agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Employee **SIGN HERE:** Print Name Date:

My signature acknowledges both the applicable arbitration disclosure of the health plan I indicated in Section C and my decision to enroll in and/or cancel the medical, dental, vision or life coverage that I indicated 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	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
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 **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 Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 60 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 60 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 0500D 12/2013