

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 ADDRESS CHANGE **REQUIRES** A CHANGE OF HEALTH PLAN, COMPLETE AND ATTACH A NEW ENROLLMENT APPLICATION 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** to coverage will become effective on the **first day** of the month **preceding event** (marriage, birth, adoption). *Please attach a copy of marriage certificate, proof of birth (birth certificate, announcement) or legal documents as applicable.

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 MARRIAGE CERTIFICATE *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 explain:

†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 and financially dependent upon me per IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted by 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.

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 and financially dependent upon me per IRS guidelines. My children are born to me or my spouse or legally adopted by me and/or my spouse. Or if my children are born to/adopted by my 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 have cause to bring civil action against me to recover their losses.

Employee SIGN HERE:

Date:



CALIFORNIACHOICE STAFF USE BELOW THIS POINT

PLAN CODE

PROCESSED

EMPLOYEE #

EFFECTIVE DATE