

D. 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.

E. Your LEGAL Acknowledgement (Read, Sign and 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 51+ 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 51+ 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 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 CaliforniaChoice 51+ 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 51+ 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 51+ 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.

Employee Sign Here:

Date:

