

RENEWAL

Change Request Form

- Use blue or black ink pen
- Do not shrink this form

Fax completed form to (714) 664-1711
or for assistance call (866) 451-7587

1 Employee Information

| | | | | | | | | | | | | | | | | | |
|---|--|--|----------|--|--|----------------|--|--|--------------|--------|--|---------------------------------|--|------------------------------|--|--|--|
| Employee Last Name | | | | | | | | | | | | Employee Social Security Number | | | | | |
| Employee First Name | | | | | | | | | | | | Middle Initial | | CaliforniaChoice 51+ Group # | | | |
| Street Address | | | | | | | | | | Apt. # | | City | | | | | |
| State | | | Zip Code | | | Home Telephone | | | Company Name | | | | | | | | |
| Address listed is: <input type="checkbox"/> Residential Address <input type="checkbox"/> Mailing Address <input type="checkbox"/> Check here if new address | | | | | | | | | | | | | | | | | |

2 Adding/Cancelling A Spouse/Domestic Partner/Dependent

Complete this section to add/cancel dependent coverage. If adding dependents age 19-23 to PPO medical coverage and/or 19-24 to PPO dental coverage, please also complete the student verification form.

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 | | | | | | | | | |
| <input type="checkbox"/> Cancel | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision | | — — | / / | | | To change your physician or dentist, please contact your carrier. Refer to your handbook for carrier information. | | |
| SPOUSE/DOMESTIC PARTNER | | | | | | | | | |
| <input type="checkbox"/> Spouse OR <input type="checkbox"/> Domestic Partner | | <input type="checkbox"/> Male <input type="checkbox"/> Female | — — | / / | | | | | <input type="checkbox"/> |
| <input type="checkbox"/> Add' <input type="checkbox"/> Cancel | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision | | — — | / / | | | | | <input type="checkbox"/> |
| CHILDREN | | | | | | | | | |
| <input type="checkbox"/> Add' <input type="checkbox"/> Cancel | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | — — | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> |
| <input type="checkbox"/> Add' <input type="checkbox"/> Cancel | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | — — | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> |
| <input type="checkbox"/> Add' <input type="checkbox"/> Cancel | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | — — | / / | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | <input type="checkbox"/> |

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: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. 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 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 have cause to bring civil action against me to recover their losses.

Employee Name _____

Group Number _____

3 Health Plan & Medical Benefit Design Change/Add

(CHECK ONE) **ADD** **CHANGE**

Indicate **NEW** benefit design you are requesting:

| HMO | | PPO |
|---|---|--|
| Health Net | Kaiser Permanente | Health Net Life Insurance Company |
| <input type="checkbox"/> CalChoice 51+ HMO 15 <input type="checkbox"/> CalChoice 51+ HMO 25 <input type="checkbox"/> CalChoice 51+ HMO 40 <input type="checkbox"/> Elect Open Access | <input type="checkbox"/> CalChoice 51+ HMO 15 <input type="checkbox"/> CalChoice 51+ HMO 25 <input type="checkbox"/> CalChoice 51+ HMO 40 <input type="checkbox"/> HDHP 1500* <small>*HSA-Qualified High Deductible Health Plan</small> | <input type="checkbox"/> PPO 250 <input type="checkbox"/> PPO 500 <input type="checkbox"/> PPO 1000 <input type="checkbox"/> PPO 1500 <input type="checkbox"/> HSA 1500 <input type="checkbox"/> HSA 2000 <input type="checkbox"/> Flex Net (Out of Area Only) |

Please select a Primary Care Physician (not needed for Kaiser Permanente, PPO Enrollees or members changing benefit level only) for each currently enrolled family member. Do not list those already provided in section 2.

| Last Name | First Name | Name | PCP (HMO only) | ID # | Please verify that doctor is still affiliated with above plan! | ✓ below if current doctor |
|-------------------|------------|------|----------------|------|--|---------------------------|
| YOU | | | | | | |
| | | | | | | <input type="checkbox"/> |
| DEPENDENTS | | | | | | |
| | | | | | | <input type="checkbox"/> |
| | | | | | | <input type="checkbox"/> |
| | | | | | | <input type="checkbox"/> |
| | | | | | | <input type="checkbox"/> |
| | | | | | | <input type="checkbox"/> |

4 Dental Benefit Design Change/Add

(CHECK ONE) **ADD** **CHANGE**

| | |
|--|---|
| <input type="checkbox"/> Dental Plan FDH 100 <input type="checkbox"/> Dental Plan 1000† <input type="checkbox"/> Dental Plan 3000† | <input type="checkbox"/> Dental Plan 3500 <input type="checkbox"/> Dental Plan 4000 <input type="checkbox"/> Dental Plan 5000 |
| † If electing any plan above, please select a dentist | |
| Dentist's Name _____ | ID # _____ |
| <input type="checkbox"/> Check if current dentist | |

5 Voluntary Vision Add

Check this box to add Voluntary Vision (fill out section 2 to add dependents)

Your LEGAL Acknowledgement (Please read, sign and date where indicated on next page)

By submitting this signed application, I agree and understand that the health plan I have chosen through the CaliforniaChoice 51+ 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 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

(continued on next page)

Your LEGAL Acknowledgement (continued)

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: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. 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 I, myself and my dependents have met all of the eligibility requirements.

California law prohibits an HIV test from being required or used by Health Care Service Plans and health insurance companies as a condition of obtaining coverage.

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ARBITRATION: I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and my health plan, whether arising out of tort or otherwise, must be submitted to binding arbitration and in lieu of a jury or court trial if not satisfactorily resolved through my health plan's grievance process.

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, the Safeguard Entities and/or the Fidelity 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, the Safeguard Entities and/or the Fidelity 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, the Safeguard Entities and/or the Fidelity 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, the Safeguard Entities and/or the Fidelity 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 my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in 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 contained in the Evidence of Coverage.

Employee **SIGN HERE FOR MEDICAL, DENTAL, LIFE OR VISION COVERAGE:**

Print Name

Date:



My signature acknowledges both the applicable arbitration disclosure of the HMO I selected in Section 3 and my decision to enroll in the medical, dental or vision coverage that I selected in Sections 3, 4 and/or 5.