

# Employer Change Request Form



**CaliforniaChoice 51+**  
Your Health. Your Choice.®

www.calchoiceplus.com

Fax completed form to (714) 664-1711

Group Name <input style="width:95%" type="text"/>	Group # <input style="width:20px" type="text"/> <input style="width:20px" type="text"/> <input style="width:20px" type="text"/> <input style="width:20px" type="text"/> <input style="width:20px" type="text"/>
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**\*\*RENEWAL ONLY\*\*** Changes below are **only** allowed at Renewal (Anniversary Date)

**A. PREMIUM CONTRIBUTION CHANGE** Please select **ONE** option

Note: Dependent contributions are optional for employers. †If you wish to suppress all contribution figures, please check option 4.

**OPTION 1**  **PERCENTAGE OF MEDICAL COST**

**STEP 1: Enter the percentage amount you will contribute toward:**

Employee Premium: \_\_\_\_\_ % (50% minimum required)    Dependent Premium: \_\_\_\_\_ % (write -0- if none)

**STEP 2: Apply contribution toward HMO, PPO or ANY Plan Option**

- HMO**
- Lowest cost plan in HMO benefit level: \_\_\_\_\_
  - Highest cost plan in HMO benefit level: \_\_\_\_\_
  - All plans in HMO benefit level: \_\_\_\_\_
  - Specific Health Plan (select one from list): **➔** \_\_\_\_\_

Carrier	HMO 15	HMO 15 Value	HMO 20/\$500 Value	HMO 25	HMO 25 Value	Elect Open Access	HMO 40	HMO 40 Value
CIGNA	<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>	
Health Net	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Permanente	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

NOTE: Value plans are available for contribution benefit level selection

- PPO**
- PPO 250     PPO 500     PPO 1000     PPO 1500
  - HSA 1500     HSA 2000

- HDHP**     HDHP 1500\* (Available through Kaiser Permanente only)

- Any HMO or PPO** plan selected by employee

\*HSA-qualified High Deductible Health Plan

**OPTION 2**  **EMPLOYER FIXED DOLLAR AMOUNT FOR MEDICAL**

Enter the dollar amount(s) you will contribute toward any plan selected by the employee:

\$ \_\_\_\_\_ for Employee    **OR**    \$ \_\_\_\_\_ Combined amount for Employee and Dependents  
 \$ \_\_\_\_\_ for Dependents

**OPTION 3**  **EMPLOYER DENTAL CONTRIBUTION**

Enter the percentage amount you will contribute:

\_\_\_\_\_ % for Employee (50% minimum required)    **Applied toward:**    Dental Plan Number \_\_\_\_\_  
 \_\_\_\_\_ % for Dependents

**†OPTION 4**  **SUPPRESS ALL CONTRIBUTION**

Suppressing contributions will result in only full premium amounts reflected on invoices and worksheets. **Contribution must still be at least 50% of lowest cost plan for each employee.**

**B. ADD/CHANGE CHIROPPLUS TO:**     Chiropractic Only     Chiro & Acupuncture

**C. CHANGE WAITING PERIOD TO:**     30 days     60 days     90 days     180 days     365 days

All employees currently in the waiting period must either enroll at Renewal or be subject to the new waiting period selected.

**\*OFF RENEWAL\*** Changes below may be made at any time once a year

**D. CHANGE ADDRESS/PHONE/FAX** Please list the group's new billing address below:

( Check here if billing address and street address are the same)

Group's new **billing** address: \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group's new **street** address: \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check here if phone and/or fax number has not changed  
 Please list group's new phone and/or fax number: \_\_\_\_\_  
 Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

(Continued on other side)

Group Plan Administrator Signature

Print Name

Date

**\*OFF RENEWAL\* (continued)** Changes below may be made at any time once a year

**E. ADD/CHANGE CONTACT** *Please add the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the group.*

Primary Contact \_\_\_\_\_ Title/Position \_\_\_\_\_  
 Direct Line \_\_\_\_\_ Email \_\_\_\_\_

Additional Contact \_\_\_\_\_ Title/Position \_\_\_\_\_  
 Direct Line \_\_\_\_\_ Email \_\_\_\_\_

*Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:*

Remove Contact \_\_\_\_\_ Title/Position \_\_\_\_\_  
 Remove Contact \_\_\_\_\_ Title/Position \_\_\_\_\_

**F. ADD CHIROPPLUS**  Chiropractic Only  Chiro & Acupuncture

**G. ADD SECTION 125** *\*A one time \$100 Enrollment Fee must be submitted*

1. Name of Company President, Principal, or Partners: \_\_\_\_\_ 2. Name of Corporate Secretary: (if applicable) \_\_\_\_\_

3. Plan Number: \_\_\_\_\_ (usually 501) 4. State of Incorporation (if applicable): \_\_\_\_\_

5. Company Structure:  
 Corporation  S Corporation  Partnership  Sole Proprietorship  LLC  Other \_\_\_\_\_

6. Premium payments may be elected for:  Medical  Dental  Other: \_\_\_\_\_

7. Last day of first Plan year: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.

**Participation Limitations**

Section 125 Premium Only Plan rules require that all participants be employees. Please be advised that 2% (or greater) shareholders in an S-Corporation, Sole Proprietors in a Sole Proprietorship and Partners in a Partnership are not considered employees as defined by Tax Code, and therefore, are ineligible to participate. **IMPORTANT** Read the information provided in the CaliforniaChoice 51+ Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

**H. ADD/CHANGE LIFE INSURANCE**

**Requirements:**

- 100% of eligible employees (whether enrolling or waiving medical) must enroll for life coverage. Employee Enrollment Applications (Form PL 0310) must be submitted by each employee with Sections A, C, & F completed.
- A reconciled DE-6 must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, T=terminated, S=seasonal, etc.)
- 100% employer-paid premiums
- Life coverage added outside of initial enrollment is non-guaranteed issue and must be medically underwritten

<input type="checkbox"/> <b>OPTION 1: Flat Amount</b> Select a Flat amount for all employees:  Amount \$: <input type="text"/>	← CHOOSE ONE OPTION ONLY → Life Amounts available for both options			<input type="checkbox"/> <b>OPTION 2: Scheduled Amount</b> Select up to 6 amounts with the highest being NO MORE THAN 5 X the lowest. (Amounts must be in increments of \$5000)																		
	<table border="1"> <thead> <tr> <th>Group Size</th> <th>Minimum</th> <th>Maximum</th> </tr> </thead> <tbody> <tr> <td>51-74</td> <td>\$10,000</td> <td>\$50,000</td> </tr> <tr> <td>75-99</td> <td>\$10,000</td> <td>\$75,000</td> </tr> <tr> <td>100-124</td> <td>\$10,000</td> <td>\$100,000</td> </tr> <tr> <td>125-149</td> <td>\$10,000</td> <td>\$125,000</td> </tr> <tr> <td>150-199</td> <td>\$10,000</td> <td>\$200,000</td> </tr> </tbody> </table>	Group Size	Minimum		Maximum	51-74	\$10,000	\$50,000	75-99	\$10,000	\$75,000	100-124	\$10,000	\$100,000	125-149	\$10,000	\$125,000	150-199	\$10,000	\$200,000		
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# of eligible employees: <input type="text"/>																						

**I. ADD DENTAL 100** **Effective date is the 1st day of the month following request**

To add the following benefits as an option for your employees, complete the forms as indicated below:

**J. ADD BUY-UP DENTAL** **\*Complete the Buy-up Dental Application (Form # PL 0566)**

**K. ADD VOLUNTARY VISION** **\*Complete the Voluntary Vision Application (Form # PL 0285)**

Group Name \_\_\_\_\_ Date \_\_\_\_\_

Group Plan Administrator Signature \_\_\_\_\_ (Person signing form must be authorized contact on record for CaliforniaChoice 51+) Print Name \_\_\_\_\_