CaliforniaChoice®
Your Health. Your Choice.®

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www.calchoice.com

Employer Change Request Form

Group Name ______________________ **CaliforniaChoice® Group #** ☐☐☐☐☐

❑ A. 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

❑ B. 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 ______________________

❑ C. ADD LIFE INSURANCE

Groups wishing to apply for Life amounts higher than the guaranteed issue amounts below must be medically underwritten. Please contact our Customer Service Center for more information.

Requirements:

1. 100% of eligible employees (whether enrolling or waiving medical) must enroll for life coverage. Employee Enrollment Applications (**Form CC 0310**) must be submitted by each employee with Sections A, D, & E completed.
2. A reconciled quarterly/annual wage report must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, T=terminated, S=seasonal, etc.)
3. 100% employer-paid premiums

Select a Flat amount for all employees:

Amount $: ☐

# of eligible employees: ☐

Guaranteed Issue Amounts

Eligible Employees	Minimum	Maximum
2-5	$5,000	$5,000
6-10	$5,000	$10,000
11-25	$5,000	$25,000
25-50	$5,000	$50,000

▼▼▼▼ *CHIROPRACTIC/ACUPUNCTURE, DENTAL AND VISION CHANGES MAY ONLY BE MADE ONCE A YEAR* ▼▼▼▼

❑ D. ADD CHIRO*PLUS*

❑ Chiropractic Only ❑ Chiro & Acupuncture

❑ E. 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 indicated below (Login at www.calchoice.com to download forms)

F. ADD VOLUNTARY DENTAL 3000

***Complete the Voluntary Dental 3000 Application (Form # CC 0567)**

G. ADD BUY-UP DENTAL

***Complete the Buy-up Dental Application (Form # CC 0566)**

H. ADD VOLUNTARY VISION

***Complete the Voluntary Vision Application (Form # CC 0285)**

❑ I. 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)
(If not indicated, 501 will be used)

4. State of Incorporation (if applicable): ______________________

5. Company Structure: ❑ Corporation ❑ S Corporation ❑ LLC ❑ Sole Proprietorship ❑ Partnership ❑ Other__________________

6. Premium payments may be elected for: ❑ Medical ❑ Dental ❑ Other: ________________

7. Last day of first Plan year: ________/______/________
(If not indicated, last day of medical plan year will be used)

Usually 12 months after the effective date of coverage; subsequent plan years will be the 12 month period following this date.

Participation Limitations: P.O.P. rules require that all participants in the plan 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 in the P.O.P. **IMPORTANT:** Read the information provided in the California*Choice*® Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Additional change options are located on reverse side

****RENEWAL ONLY**** Changes below are **only** allowed at Renewal (Anniversary Date)

❑ J. NETWORK

IMPORTANT: This change request must be submitted **a minimum of 5 business days** prior to your renewal date and include Renewal Change Request Forms for Anthem Blue Cross and Health Net enrollees to request their provider with these new networks.

I am electing to offer:

❑ Standard Anthem Blue Cross and Health Net Provider Networks to my employees.
❑ Anthem Blue Cross Select HMO and Health Net Silver HMO Provider Networks to my employees.

❑ K. PREMIUM CONTRIBUTION CHANGE

Please select ONE option from items 1-3

*Note: Dependent contributions are optional for employers. †If you wish to suppress contribution figures, please check option 5.

OPTION 1 ❑ PERCENTAGE OF 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 one HMO, PPO or ANY Plan Option (A, B, or C)

A. ❑ 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): ➔

NOTE: Value Plans are available for contribution benefit level selection

Carrier	HMO 15	HMO 25	HMO 25 Value	Elect Open Access 25 Plus	Elect Open Access	Elect Open Access 40 Plus	HMO 30	HMO 30 Value	HMO 40	HMO 40 Value
Anthem Blue Cross	❑	❑	❑				❑		❑	❑
Health Net	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Kaiser Permanente	❑	❑					❑		❑	
Sharp	❑	❑					❑		❑	
Western Health Advantage	❑	❑					❑		❑	❑

B. ❑ PPO: ❑ 750 ❑ 750 GenRx ❑ 3000 ❑ HSA 1800** ❑ 1000 ❑ 1000 GenRx ❑ 4000 ❑ HSA 2500**

***HSA-Qualified High Deductible Health Plan*

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE

C. ❑ Any HMO or PPO plan selected by employee

OPTION 2 ❑ EMPLOYER FIXED DOLLAR AMOUNT

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

$ ________ for Employee
$ ________ for *Dependents

OR $ ________ Combined amount for Employee and *Dependents

OPTION 3 ❑ EMPLOYEE FIXED DOLLAR AMOUNT

STEP 1: Enter the dollar amount(s) the employee will contribute:

$ ______ Employee Cost $ ______ *Additional for Spouse $ ______ *Additional for Child(ren) $ ______ *Additional for Family

STEP 2: Apply contribution toward one HMO or PPO Option (A or B):

A. ❑ 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): ➔

NOTE: Value Plans are available for contribution benefit level selection

Carrier	HMO 15	HMO 25	HMO 25 Value	Elect Open Access 25 Plus	Elect Open Access	Elect Open Access 40 Plus	HMO 30	HMO 30 Value	HMO 40	HMO 40 Value
Anthem Blue Cross	❑	❑	❑				❑		❑	❑
Health Net	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Kaiser Permanente	❑	❑					❑		❑	
Sharp	❑	❑					❑		❑	
Western Health Advantage	❑	❑					❑		❑	❑

B. ❑ PPO: ❑ 750 ❑ 750 GenRx ❑ 3000 ❑ HSA 1800** ❑ 1000 ❑ 1000 GenRx ❑ 4000 ❑ HSA 2500**

***HSA-Qualified High Deductible Health Plan*

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE

OPTION 4 ❑ EMPLOYER DENTAL CONTRIBUTION

Enter the percentage amount you will contribute:

__________ % for Employee (50% minimum required)
__________ % for *Dependents

Applied toward (check one box only):

❑ Prepaid 1000 ❑ EPO 3000 ❑ PPO 4000
❑ Prepaid 3000 ❑ EPO 3500 ❑ PPO 5000

OPTION 5 ❑ †SUPPRESS 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.**

❑ L. 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.

❑ M. CHANGE HOURS OF ELIGIBILITY

❑ From 30+ to 20+ hours per week ❑ From 20+ to 30+ hours per week

I understand and agree to the following: 1) Coverage must be extended to all employees working the number of hours per week considered to be eligible. 2) 70% of employees working the number of hours per week considered to be eligible must enroll. 3) Employer contribution for all employees must be the same. 4) Once the Hours of Eligibility change becomes effective, it must be maintained until our anniversary date.

Group Name ______________________

Date MO __ DAY __ YEAR __

California*Choice*® Group # ______

____
Group Plan Administrator Signature *(Person signing form must be authorized contact on record for CaliforniaChoice)*

____
Print Name

***Log onto www.calchoice.com (Broker or Employer log-in) to download forms and brochures**