

## Change Request Form

- Use blue or black ink pen
- Do not shrink this form
- Do not use this form to change your physician or dentist
- Fax completed form to (866) 251-4724 or email to: memberprocessing@hsacalifornia.com
- For assistance call (866) 251-4718

Check here if changes are to be effective at Renewal  
Complete steps A through E as applicable

### A Complete Employee Information

Employee Last Name											Employee Social Security Number																					
Employee First Name											Middle Initial				HSA California Group #																	
Street Address											Apt. #		City																			
State			Zip Code			Home Telephone			Company Name																							
<input type="checkbox"/> Name Change/Correction: <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="11">New First Name</td> </tr> <tr> <td colspan="11">New Last Name</td> </tr> </table>											New First Name											New Last Name										
New First Name																																
New Last Name																																

Check here if new address:  Residential Address  Mailing (Address changes will be effective the 1st day of the month following the receipt of the request)

### B Only Complete to Add/Cancel Dependent

**Cancellations** of coverage will take effect on the **last day** of the month **after receipt** of your request by HSA California®. Cancellations at Renewal will take effect on the group's Renewal date.

**Additions:** coverage (due to a qualifying event that took place between the 1st and 15th of the month) will be effective on **the date of the qualifying event**.

**Additions:** coverage (due to a qualifying event that took place between the 16th and the end of the month) will be effective on the **1st day** of the month **following event** (marriage, domestic partnership, birth, adoption/legal ward).

<b>IF APPLICABLE:</b>	Date of marriage/divorce if adding/cancelling spouse: <input type="text"/>	If child custody, enter date of adoption: <input type="text"/>	Reason for Cancellation: <input type="text"/>
	<i>*Attach copy of marriage license and/or certificate as applicable</i>	<i>*Attach copy of legal documentation</i>	

Coverage Type	Last Name	First Name	Social Security Number	Birth Date (Month/Day/Year)	Dependent Disabled?	MEDICAL ONLY Primary Care Physician Name	MEDICAL ONLY Primary Care Physician ID #	✓ below if current doctor
<b>EMPLOYEE</b> <input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision			— —	/ /		<b>To change your physician or dentist, please contact your carrier. Refer to your handbook for carrier information.</b>		
<input type="checkbox"/> Spouse OR <input type="checkbox"/> Domestic Partner ↓ <input type="checkbox"/> Add* <input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Vision		<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /				
<b>CHILDREN</b> <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"/> Daught.	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<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"/> Daught.	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<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"/> Daught.	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No			

**\*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 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 HSA California benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through HSA California 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.

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.

**IMPORTANT: Regarding Steps C and D, plan changes are only allowed at Renewal. However, employees who acquire a new dependent (i.e. newborn, new spouse etc.) are able to change their coverage outside of the Renewal Period.**

**C Only Complete to Add/Change Health Plan & Medical Benefit**

(CHECK ONE)  ADD  CHANGE

Indicate NEW **MEDICAL** benefit design you are requesting (select one plan only):

HMO (Kaiser Permanente)	HMO (Western Health)	PPO (Health Net)	Indemnity (Health Net)
<input type="checkbox"/> HMO 2200 <input type="checkbox"/> HMO 2600	<input type="checkbox"/> HMO 1800 <input type="checkbox"/> HMO 2800B	<input type="checkbox"/> PPO 2500 <input type="checkbox"/> PPO 3500 <input type="checkbox"/> PPO 4500	<input type="checkbox"/> Flex Net <small>Only available if Out of State and not eligible for PPO plans. Not an HSA-compatible plan.</small>

**IMPORTANT "OPT OUT" NOTICE ABOUT THE PRIVACY OF YOUR INFORMATION:** If your Employer elects to automatically open, and possibly fund, Health Savings Accounts for each Employee, we will provide Bancorp with personal information about you necessary for Bancorp to open and maintain an HSA in your name. If you DO NOT want that information shared with Bancorp, you MUST indicate that by checking the "Opt Out" box below. Checking the "Opt Out" box will not allow Bancorp to automatically open your HSA and may hinder your Employer's ability to fund said account.

OPT OUT: I DO NOT want my information disclosed to or used by Bancorp

**D Only Complete to Add/Change Optional Benefits**

Before completing Optional Benefits section, check with your employer to see if these Optional Benefits are offered.

**Dental Benefit Design**

Dependents enrolled for dental must match dependents enrolled for medical (except voluntary dental or children under the age of 3).

(CHECK ONE)  ADD  CHANGE

- Prepaid 1000<sup>†</sup>  EPO 3000  PPO 4000  Voluntary Prepaid 3000<sup>†</sup>  
 Prepaid 3000<sup>†</sup>  EPO 3500  PPO 5000

<sup>†</sup> Select a dentist for Prepaid Plans 1000 or 3000 by listing them below. If a dentist is not listed, one will be assigned

- Check if dentist chosen is current provider  
 Check if you would like a dentist assigned

Dentist: \_\_\_\_\_

ID#: \_\_\_\_\_

**Voluntary Vision Add**

- Check this box to add Voluntary Vision

**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 <sup>†</sup> 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. <sup>†</sup>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 Complete Your Legal Acknowledgement (Read, Sign and Date Where Indicated)**

By submitting this signed application, I agree and understand that the health plan I have chosen through the HSA California® 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 HSA California 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 HSA California 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 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 born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partners.

I understand that the preceding statements are subject to audit at any time and agree to provide HSA California 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 HSA California benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through HSA California 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 listed on page 4 of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

**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 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 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, 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 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 I am enrolled in a group that is subject to ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, 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*.

**WESTERN HEALTH ADVANTAGE ENROLLEES:**

**Arbitration Agreement:** I agree and understand that any and all disputes between myself (including any heirs or assigns) and Western Health Advantage, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by submission to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. The parties, including any heirs or assigns, to this arbitration agreement are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

Employee SIGN HERE:

Print Name

Date:



My signature acknowledges both the applicable arbitration disclosure of the health plan I indicated in Section C and my decision to enroll in and/or cancel the medical, dental, vision or life coverage that I indicated in Sections C and D.

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met:
<p><b>New Spouse/ New Stepchild</b></p>	<p>If marriage occurred before the 16th of the month, coverage begins on the first day of the month of the date of marriage.</p> <p>If marriage occurred on the 16th of the month or after, coverage begins on the first of month <u>following</u> date of marriage.</p>	<p>Requirements that <u>MUST</u> be met:</p> <ul style="list-style-type: none"> <li>■ New spouse must be legally married to the employee</li> <li>■ New stepchild must also meet the dependent children requirements listed below</li> </ul>
<p><b>New Baby, Adopted Child, Non-Temporary Legal Ward, and Dependent Children</b></p>	<p>If birth/date of placement occurred before the 16th of the month, coverage begins on the first day of the month of the date of birth/placement.</p> <p>If birth/date of placement occurred on the 16th or after, child is automatically covered at no cost under Subscriber between date of birth/placement and the first of the <u>following</u> month. Coverage for the dependent begins on the first of the month following the birth/date of placement.</p>	<p>MEDICAL, VISION and <b>SMILESAVER DENTAL</b> Dependent Eligibility:</p> <ul style="list-style-type: none"> <li>■ Born to, a stepchild or legal ward of, or adopted by eligible employee, employee spouse or domestic partner</li> <li>■ Under age 26 (unless disabled, disability diagnosed prior to age 26)</li> </ul> <p><b>AMERITAS DENTAL</b> Dependent Eligibility:</p> <ul style="list-style-type: none"> <li>■ Born to, a stepchild or legal ward of, or adopted by eligible employee, employee spouse or domestic partner</li> <li>■ Financially dependent upon the employee per IRS guidelines</li> <li>■ Unmarried or not involved in a domestic partnership</li> <li>■ Under age 26 (unless disabled, disability diagnosed prior to age 26).</li> </ul> <p><b>Disabled Dependents:</b> Dependents who are incapable of self-support because of continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of disability will be requested. Once the child reaches the age limit for coverage, verification of eligibility will occur annually at the child's birthday.</p> <p style="text-align: center;"><b>Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</b></p>
<p><b>Domestic Partner/ Child of Domestic Partner</b></p>	<p><u>During Initial Enrollment or Group's Annual Renewal:</u> Coverage begins on group's effective date.</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month.</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a domestic partner will require a state-stamped copy of the Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnerships. If domestic partnership is established before the 16th of the month, coverage begins on the first day of month of the event. If domestic partnership is established on the 16th of the month or after, coverage begins on the first of the month following date of event.</p>	<p>For a Domestic Partner to qualify, Employee and Domestic Partner must:</p> <ul style="list-style-type: none"> <li>■ Share a common residence</li> <li>■ Neither is married under either statutory, common law or part of another domestic partnership</li> <li>■ Both be 18 years of age or older</li> <li>■ Share an intimate and committed relationship</li> <li>■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship</li> <li>■ Both be mentally competent</li> <li>■ Not related by blood to a degree of closeness that would prohibit marriage in this state</li> <li>■ Agree to notify HSA California® immediately upon termination of domestic partnership</li> </ul> <p><u>Children of Domestic Partner must also meet the dependent children requirements listed above</u></p> <p>Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership.</p> <p style="text-align: center;"><b>Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment</b></p>