

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 (800) 556-8514
- For assistance call (800) 580-9626

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

A Complete Employee Information

Employee Last Name												Employee Social Security Number																																											
Employee First Name												Middle Initial				Group #																																							
Address listed is: <input type="checkbox"/> Residential Address <input type="checkbox"/> Mailing Address <input type="checkbox"/> Check here if new address																																																							
Street Address												Apt. #				City																																							
State												Zip Code				Home Telephone				Company Name																																			
<input type="checkbox"/> Name Change/Correction: <table border="1" style="display: inline-table; margin-left: 10px;"> <tr> <td colspan="12">New First Name</td> <td colspan="4">Middle Initial</td> </tr> <tr> <td colspan="12">New Last Name</td> <td colspan="4"></td> </tr> </table>												New First Name												Middle Initial				New Last Name																											
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New Last Name																																																							

B Coverage Change

THIS FORM MUST BE RECEIVED BY CHOICE ADMINISTRATORS® NO LATER THAN 31 DAYS AFTER THE EVENT TAKES PLACE IN ORDER TO QUALIFY FOR COVERAGE.

COMPLETE THIS SECTION TO ADD/CANCEL DEPENDENT COVERAGE

Dependent enrollment must be the same for all lines of coverage for medical and dental.

IF APPLICABLE:	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"/>
	<small>*Attach copy of marriage license and/or certificate</small>	<small>*Attach copy of legal documentation</small>	

	Coverage Type	Last Name	First Name	Sex	Social Security Number	Birth Date (Month/Day/Year)	Dependent Disabled?
EMPLOYEE	<input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	
	<input type="checkbox"/> Spouse OR <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Add ¹ <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	
C H I L D R E N	<input type="checkbox"/> Add ¹ <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add ¹ <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add ¹ <input type="checkbox"/> Cancel	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: If Last Name of spouse/child(ren) is different from Employee's Last Name, please give brief explanation:

*Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

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.

My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed 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 Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution 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 _____

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 Medical Benefit (Change/Add)

INDICATE **NEW** BENEFIT DESIGN YOU ARE REQUESTING:

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

- HMO 10** **HMO 30** **HMO 20/\$1000** **HDHP 1900***
 HDHP 2700* **POS 20/\$1000** **PPO 30/\$500**

*HSA-Qualified High Deductible Health Plan

D Dental Benefit (Change/Add)

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

- DHMO 200[†]** **PPO 1000** **FFS 1000**
 DHMO 250[†] **PPO 1500** **FFS 1500**

[†] If you choose plans 200 or 250, you must select a dentist:	DENTIST'S NAME	
	ID #	<input type="checkbox"/> CHECK IF CURRENT DENTIST

E 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 designations 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.

F Your LEGAL Acknowledgement (Read, Sign & Date Below)

By submitting the signed application, I agree and understand that the health plan chosen through the Kaiser Permanente Choice Solution 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, copayments, 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 Kaiser Permanente Choice Solution 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 CHOICE Administrators® 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 partner.
- My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed 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 CHOICE Administrators 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 Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution 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 myself and my dependents have met all of the eligibility requirements listed on the fourth page 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.

Kaiser Foundation Health Plan 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), Kaiser Permanente Insurance Company (KPIC), 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 or coverage by KPIC, 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* and in the *Certificate of Insurance*.

[†] Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service Plan; 2) the PPO Plan; and 3) the KPIC Dental Plans.

Employee SIGN HERE:

Date:



Who can be covered?

Effective dates

Requirements that MUST be met:

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met:
New Spouse	Coverage begins on the first of month <u>following</u> date of marriage	<ul style="list-style-type: none"> ■ Spouse must be legally married to eligible employee and the eligible employee must agree to notify CHOICE Administrators® Insurance Services, Inc. immediately upon termination of the marriage.
New Baby, Dependent Child, Grandchild†	Coverage will begin from the moment of birth through the end of the calendar month of birth, or the mother's hospitalization if she is a member, whichever is later. Premiums for continuation of coverage for the dependent will be charged beginning on the first of the month <u>following</u> the birth.	<p><u>MEDICAL Dependent eligibility:</u></p> <ul style="list-style-type: none"> ■ Born to or grandchild† of the eligible employee, spouse of the eligible employee or domestic partner ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) <p><u>DENTAL Dependent eligibility:</u></p> <ul style="list-style-type: none"> ■ Born to or grandchild† of the eligible employee, spouse of the eligible employee or domestic partner ■ Dependent on the employee for at least 50% of his/her economic support ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) <p>Disabled Dependents: 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; background-color: black; color: white; padding: 5px;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Adopted Child, Stepchild, Non-Temporary Legal Ward	Coverage is effective on the date the member gains the right to control the dependent's healthcare, and premiums will be charged the first of the month <u>following</u> this date.	<p><u>MEDICAL Dependent eligibility:</u></p> <ul style="list-style-type: none"> ■ Adopted by, stepchild of, or non-temporary legal ward of the employee ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) <p><u>DENTAL Dependent eligibility:</u></p> <ul style="list-style-type: none"> ■ Adopted by, stepchild of, or non-temporary legal ward of the employee ■ Dependent on the employee for at least 50% of his/her economic support ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) <p>Disabled Dependents: 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; background-color: black; color: white; padding: 5px;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Domestic Partner	<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 Registered domestic partnership within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnership</p>	<p>The employee and domestic partner must:</p> <ul style="list-style-type: none"> ■ Share a common residence ■ Not be married under either a statutory or common law or part of another domestic partnership ■ Be 18 years of age or older ■ Share an intimate and committed relationship ■ Both be mentally competent ■ Not be related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify CHOICE Administrators Insurance Services, Inc. immediately upon termination of the domestic partnership <p style="text-align: center; background-color: black; color: white; padding: 5px;">Employee and Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>

† Grandchild may be covered if the parent is a dependent of the covered employee and the parent is also enrolled.