ChoiceBuilder®

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Change Request Form

DO NOT USE THIS FORM TO CHANGE YOUR DENTIST

- Complete this form **ONLY** if you are an active ChoiceBuilder® member who wants to update personal information, make plan changes, add/cancel dependent coverage or voluntarily cancel coverage.
- E-mail Address: memberprocessing@choicebuilder.com
- **PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING.**

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

A. COMPLETE EMPLOYEE INFORMATION

Employee Last Name | **Social Security #**

Employee First Name | **M.I.** | **Group #** B

Check here if new address: ☐ Residential Address ☐ Mailing

Physical Address (Do not use P.O. Box for residential address) | **Apt #** | **City**

State | **ZIP Code** | **Phone # (XXX) XXX-XXXX** | **E-mail Address**

☐ Check here if Name Change/Correction | **New First Name** | **New Last Name**

B. ONLY COMPLETE TO CANCEL COVERAGE OR ADD DEPENDENTS

Cancellations of coverage will take effect on the **last day** of the month **after receipt** of your request by ChoiceBuilder. Cancellations at Renewal will take effect on the group's Renewal date.
Additions (Qualifying/Triggering event): Please refer to administrative handbook for effective date guidelines based on Qualifying/Triggering event.
Additions (at Renewal): Coverage will be effective on the group's renewal date.
This form must be received by ChoiceBuilder **no later than 60 days** after the event takes place if outside of renewal.

IF APPLICABLE: Date of marriage*/divorce if adding/cancelling spouse (MM/DD/YYYY) — *Attach copy of marriage license and/or certificate as applicable*

If child custody*, enter date of adoption (MM/DD/YYYY) — *Attach copy of legal documentation*

Reason for Cancellation

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
	Cancel	Add Cancel	Add Cancel	Add Cancel	Add Cancel
Coverage Type	Dental ☐ Chiro ☐ Vision ☐	Dental ☐ ☐ Vision ☐ ☐	Dental ☐ ☐ Vision ☐ ☐	Dental ☐ ☐ Vision ☐ ☐	Dental ☐ ☐ Vision ☐ ☐
Last Name					
First Name					
Social Security #		Social Security # required!	Social Security # required!	Social Security # required!	Social Security # required!
Gender		☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Disabled?* *(Complete if over age 26)*			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

*If you are enrolling a disabled dependent you must complete a Disabled Dependent Form. (Form can be found on the ChoiceBuilder website)

IF ADDING DEPENDENT(S): 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 enrolling dependents listed on page 1, 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 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.
All statements and answers I have given are true and complete. I understand it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents.
If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and my right to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.
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. The coverage may be cancelled or the employer's contract rescinded because of the performance of an act or practice constituting fraud or making of an intentional misrepresentation of a material fact to an insurance company for the purposes of defrauding the company.
I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements

CB 0500 1/2024 Eff. 4/1/2024
Choice Builder Insurance Services
CDI Entity License #0N14196

Print Employee Name _____ Group # B

IMPORTANT: Regarding Steps C & 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 BENEFITS

DENTAL - Select ONE plan:

(CHECK ONE) ☐ **ADD** ☐ **CHANGE** *Indicate **NEW** benefit design you are requesting: (see worksheet for plan availability)*

DeltaCare®USA DHMO
☐ Gold ☐ Silver ☐ Bronze

OR

PPO
☐ Platinum Plus ☐ Platinum ☐ Gold ☐ Silver

Select a Dental Office (DHMO ONLY): *(If the Dental Office selected is not available or one was not selected, the Dental Office will be assigned)*

To find a Dental Office, logon to www.choicebuilder.com and click provider search

	Employee	Spouse/Domestic Partner	Child	Child	Child
Last Name					
First Name					
Dentist Name/Office					
Dentist I.D. #					
Current Patient?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
City					

☐ Check here if you would like your Dental Plan to assign you a Primary Dental Office.

➡ To enroll more dependents, complete steps A & B on an additional Change Request Form.

** If changing dental plans or adding a plan, please select a Primary Dental Office. A Primary Dental Office (PCD) is not required for PPO benefit plans. If a PCD is not contracted with your selected Dental Plan prior to enrolling or if a PCD is not listed, one will automatically be assigned to you. For PCD changes only, please contact your Dental Plan directly.*

D. ONLY COMPLETE TO ADD/CHANGE OPTIONAL BENEFITS

VISION - Select ONE plan: *(see worksheet for plan availability)*

(CHECK ONE) ☐ **ADD** ☐ **CHANGE** *Indicate **NEW** benefit design you are requesting:*

☐ Platinum ☐ Gold ☐ Silver (Silver not available with VSP Voluntary)

CHIROPRACTIC: *(see worksheet for plan availability)*

☐ ADD ☐ CANCEL

LIFE:

Complete only if your employer has selected life coverage OR if you wish to change the existing beneficiary on your life insurance. Changes will take effect on the date it was signed.

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	Relationship to You (i.e. spouse, friend, child)	*Percentage	*Type of Beneficiary
Last Name	First Name	M.I.				
			MM/DD/YYYY			☐ Primary ☐ Secondary
			MM/DD/YYYY			☐ Primary ☐ Secondary
			MM/DD/YYYY			☐ Primary ☐ Secondary

* If you are listing more than one primary beneficiary or more than one secondary beneficiary, please enter the percentage of the insurance proceeds that each individual should receive. The percentage of insurance proceeds must equal 100% for each type of beneficiary (primary or secondary). No secondary beneficiaries will be entitled to any part of the insurance proceeds if any primary beneficiary is living at the time of death of the insured.

CB 0500 1/2024 Eff. 4/1/2024
Choice Builder Insurance Services
CDI Entity License #0N14196

E. YOUR LEGAL ACKNOWLEDGEMENT AND MANDATORY BINDING ARBITRATION AGREEMENT *(Read, sign and date where indicated)*

FOR ALL ENROLLEES:

I agree for myself and my dependents to be bound by the benefits, co-pays, deductibles, exclusions, limitations and other terms of the health plan's small group contract as administered by the state of California.

I declare under the penalty of perjury under the laws of the state of California that the followinsg statements are true, correct and pertain to the employer named on this form, myself and my dependents named on this form.

- I am considered eligible by my employer because I am a full-time employee who works the required number of hours per week.
- If I am an eligible employee applying for coverage outside of a renewal period, I have had a change in family status or have experienced another qualifying/triggering event that qualifies either me or my dependent(s) as a "Late enrollee" pursuant to California law.
- I am not a temporary, seasonal, per diem, 1099 or substitute 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 meet all eligibility requirements. **I understand** that the preceding statements are subject to audit at any time and **agree** to provide ChoiceBuilder® with any and all information necessary to prove the above statements.
- All statements and answers I have given are true and complete. **I understand** it is a crime to knowingly perform an act or practice constituting fraud or make an intentional misrepresentation of material fact to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage documents. If my plan is rescinded or canceled, I will receive from my insurer a notice at least 30 days to the effective date of the rescission explaining the reasons for the intended rescission and my rights to appeal that decision to the Commissioner of Insurance pursuant to subdivision (b) of Section 10273.4 of the California Insurance Code. Notwithstanding subdivision (a) of Section 10273.4 or any other provision of the law, I understand that after 24 months following the issuance of my health plan or insurance policy, my insurer may not rescind my health plan or insurance policy for any reason, and shall not cancel my health plan or insurance policy, limit any provisions of the health plan or policy, or raise premiums due to any omissions, misrepresentations, or inaccuracies in the application for, whether willful or not.
- **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.
- I authorize any payroll deduction that may be required towards the cost of this coverage.
- The representations made are the basis upon which coverage may be issued.
- California law prohibits HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- A policy of group health insurance shall provide equal coverage to employers for the registered domestic partner of an employee, insured, or policyholder to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee, insured, or policyholder, and shall inform employers of this coverage.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

FOR LANDMARK HEALTHPLAN ENROLLEES ONLY:

Terms and conditions of enrollment are described in your Landmark Health Plan of California, Inc. (the "Plan") Combined Evidence of Coverage and Disclosure Form, and the Group Agreement between the Plan and your Employer Group.

In the event that this application for coverage is accepted, I authorize my health care practitioner, as permitted by law, to provide the Plan with information concerning the health condition or treatment of any enrollee named above, as required for the Plan to authorize or pay for covered services provided by such practitioner.

I further authorize the Plan and any other health care plan through which I and/or my dependents have coverage to release any information to one another that would be necessary to coordinate benefits between or among the plans.

With regard to the authorizations above, I agree that a copy of this form shall be valid as the original.

I agree and understand that any and all disputes, including claims relating to the delivery of services under the plan and 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 claims subject to ERISA, between myself and my dependents enrolled in the plan (including any heirs or assigns) and Landmark Health Plan of California, Inc., or any of its parents, subsidiaries, or affiliates 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 the federal arbitration act provides for judicial review of arbitration proceedings. All parties to this agreement are giving up their constitutional right to any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

My signature acknowledges both my understanding of the information presented above as well as the decision to enroll in the coverage(s) I have selected.

Signature	Print Name	Today's Date (MM/DD/YYYY)
X		

CB 0500 1/2024 Eff. 4/1/2024
Choice Builder Insurance Services
CDI Entity License #0N14196

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met
New Spouse/ New Stepchild	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Spouse can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a spouse will require a state-stamped copy of the Marriage Certificate. If the married parties have not yet received the state-stamped copy of the Marriage Certificate, a county issued receipt displaying the names of the parties and the date of marriage may be acceptable. Married parties agree to provide a copy of the state-stamped Marriage Certificate within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the marriage was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month, coverage begins on the 1st of the month following the date of receipt.	■ New spouse must be legally married to the employee ■ New stepchild must also meet the dependent children requirements listed below
Birth/Adoption/ Legal Guardianship/ Eligible Dependent Child	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. 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 following month. Coverage for the dependent begins on the first of the month following the birth/date of placement.	**MEDICAL, CHIRO, VISION and METLIFE & SMILESAVER DENTAL** Dependent eligibility: ■ Born to, a stepchild or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **AMERITAS DENTAL** Dependent eligibility: ■ Born to, a stepchild or legal ward of, adopted by, or have an established parent-child relationship with the eligible employee, employee spouse or domestic partner ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 26 (unless disabled, disability diagnosed prior to age 26) **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. **Dependents must meet all requirements listed in order to be eligible for enrollment**
Domestic Partner/ Child of Domestic Partner	During Initial Enrollment or Group's Annual Renewal: Coverage begins on group's effective date. Involuntary Loss of Other Coverage: Domestic Partner can be added outside of Renewal only if he/she loses other coverage involuntarily. Coverage is effective the first of following month. Mid-Year Addition: Mid-year additions of a domestic partner will require a state-stamped copy of the Declaration of Domestic Partnership from the California Secretary of State within 60 days of issuance. If domestic partners have filed a Declaration of Domestic Partnership and have not yet received a copy from the state, a signed Affidavit of Domestic Partnership will be accepted.Domestic Partners agree to provide a copy of the Declaration of Domestic Partnership within 60 days of issuance. If all required documentation is received before the 16th day of the month in which the domestic partnership was established, premiums are charged for the full month and coverage begins on the date of the event. If all required documentation is received on or after the 16th day of the month, coverage begins on the 1st of the month following the date of receipt.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Both have filed a duly executed Declaration of Domestic Partnership with the Secretary of State and will provide copies to ChoiceBuilder® within 60 days of its issue. For out-of-state domestic partners, please complete the Affidavit of Domestic Partnership. ■ Agree to notify ChoiceBuilder immediately upon termination of domestic partnership. Children of Domestic Partner must also meet the dependent children requirements listed above **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**

CB 0500 1/2024 Eff. 4/1/2024
Choice Builder Insurance Services
CDI Entity License #0N14196