

Employer Change Request Form

E-mail: gpc@choiceadmin.com

PLEASE DO NOT ALTER THIS FORM AS THIS WILL DELAY PROCESSING.

Company Name

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

County

State

ZIP Code

 Group's new **street** address

Street

City

County

State

ZIP Code

☐ Check here if phone and/or
fax # has not changed

 New phone
and/or fax #

Phone # (XXX) XXX-XXXX

Fax # (XXX) XXX-XXXX

☐ 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. To add/change more contacts, complete section B on an additional application.

☐ ADD BROKER OF RECORD AS AUTHORIZED GROUP CONTACT

I understand that by electing to add my Broker of Record as an Authorized Group Contact, my Broker of Record will have the ability to make changes on behalf of my group, which may result in a change in premium(s) and/or cancellation of coverage(s).

Primary Contact

Title/Position

Direct Phone # (XXX) XXX-XXXX

Extension #

E-mail Address

Additional Contact

Title/Position

Direct Phone # (XXX) XXX-XXXX

Extension #

E-mail Address

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

Remove Contact

Remove Contact

☐ C. CHANGE INVOICE OPTION

☐ E-mail Only ☐ Paper Only ☐ Both

☐ D. CHANGE PAY PERIOD

Select the number of pay periods (Will be shown on Employee Enrollment Worksheets)

☐ 12 ☐ 24 ☐ 26 ☐ 48 ☐ 52

☐ E. ADD/CHANGE 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:**
- 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.
 - A reconciled quarterly/annual wage report must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, S=seasonal, etc.)
 - 100% employer-paid premiums

 Select a Flat amount
for all employees

Amount \$

 # of eligible
employees

Guaranteed Issue Amounts

Eligible Employees	Minimum	Maximum
1-5	\$5,000	\$5,000
6-10	\$5,000	\$10,000
11-25	\$5,000	\$25,000
26-100	\$5,000	\$50,000

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☐ **F. ADD CHIROPPLUS**

- ☐ Chiropractic Only
☐ Chiro & Acupuncture

To add the following benefits as an option for your employees, complete the forms indicated below (Login at www.calchoice.com to download forms)

G. ADD DENTAL

*Complete the Dental Application (Form # CC 0566)

H. ADD VOLUNTARY VISION

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

☐ **I. ADD SECTION 125***

1. Name of Company President, Principal, or Partners

2. Name of Corporate Secretary (if applicable)

3. Plan # (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) (MM/DD/YYYY)

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 CaliforniaChoice® Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

☐ **J. 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.**

****RENEWAL ONLY**** Changes below and on next page are only allowed at Renewal (Anniversary Date)

☐ **K. CHANGE WAITING PERIOD TO FIRST DAY OF THE MONTH FOLLOWING**

- ☐ Date of Hire ☐ 30 days ☐ 60 days (NOT to exceed 90 days)

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

☐ **L. CHANGE HOURS OF ELIGIBILITY**

- ☐ 20+ hours per week
☐ 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.

☐ **M. CHANGE ORTHO ON DENTAL PLAN**

- ☐ Add Ortho to current PPO Dental Coverage*
☐ Remove Ortho from current PPO Dental Coverage

*When adding Ortho coverage, please remember that there is a 12 month waiting period.

☐ **N. CHANGE METAL TIER**

Select ONE Metal Tier option to offer to your employees

- Total Choice** ☐ BRONZE/SILVER/GOLD/PLATINUM
Triple Choice ☐ BRONZE/SILVER/GOLD ☐ SILVER/GOLD/PLATINUM
Double Choice ☐ BRONZE/SILVER ☐ SILVER/GOLD ☐ GOLD/PLATINUM
Single Choice ☐ BRONZE ☐ SILVER ☐ GOLD ☐ PLATINUM

IMPORTANT: Metal Tier change requests should be submitted a minimum of 5 business days prior to your renewal date and include Change Request Forms for all enrollees. This will allow time for processing and submission to the health plans.

Additional change options are located on next page

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☐ O. CHANGE PREMIUM CONTRIBUTION

For medical contribution, please select Option 1, Option 2 or Option 3.

[†]If you wish to suppress contribution figures, please check Section J.

OPTION 1 ☐ PERCENTAGE OF COST

(If requesting 100% contribution, you are attesting to meeting the requirement of 70% participation.)

STEP 1: Enter the percentage amount you will contribute toward

Employee Premium

 %

Dependent Premium

 %

(write 0 if none)

STEP 2: Apply contribution toward A*, B*, C*, D, E, F, G, H* or I

(50% minimum)

(*If no HMO plan available to Employee, contribution will be based on lowest cost PPO plan)

A. ☐ Lowest cost HMO within the Metal Tier(s) selected.

B. ☐ HMO & EPO Specific Health Plan (select one benefit plan from the Metal Tier(s) selected in Section N)

	Anthem Blue Cross	Cigna + Oscar	Health Net		Kaiser Permanente	Sharp	Sutter Health Plus	United Healthcare		Western Health
BRONZE		<input type="checkbox"/> EPO C* <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E <input type="checkbox"/> EPO F	<input type="checkbox"/> HMO A		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B*			<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*
SILVER	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> EPO C <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E* <input type="checkbox"/> EPO F <input type="checkbox"/> EPO G*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D* <input type="checkbox"/> HMO E	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO E <input type="checkbox"/> HMO F <input type="checkbox"/> HMO G		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*
GOLD	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> EPO C <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E <input type="checkbox"/> EPO F <input type="checkbox"/> EPO G	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D <input type="checkbox"/> HMO E	<input type="checkbox"/> HMO F <input type="checkbox"/> HMO G <input type="checkbox"/> HMO H <input type="checkbox"/> HMO I	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D <input type="checkbox"/> HMO E*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO D	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO F <input type="checkbox"/> HMO G <input type="checkbox"/> HMO H <input type="checkbox"/> HMO J	<input type="checkbox"/> HMO L <input type="checkbox"/> HMO M <input type="checkbox"/> HMO N <input type="checkbox"/> HMO O <input type="checkbox"/> HMO P <input type="checkbox"/> HMO Q	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D*
PLATINUM	<input type="checkbox"/> HMO A	<input type="checkbox"/> EPO C <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E <input type="checkbox"/> EPO F <input type="checkbox"/> EPO G	<input type="checkbox"/> HMO C <input type="checkbox"/> HMO D <input type="checkbox"/> HMO E <input type="checkbox"/> HMO F	<input type="checkbox"/> HMO G <input type="checkbox"/> HMO H <input type="checkbox"/> HMO I <input type="checkbox"/> HMO J	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO E <input type="checkbox"/> HMO G <input type="checkbox"/> HMO H	<input type="checkbox"/> HMO I <input type="checkbox"/> HMO J <input type="checkbox"/> HMO K <input type="checkbox"/> HMO L <input type="checkbox"/> HMO M <input type="checkbox"/> HMO N	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C

* HSA Qualified High Deductible Plan

C. ☐ HMO

Lowest cost benefit plan in HMO: (select one benefit level from the Metal Tier(s) selected in Section N)

BRONZE		SILVER		GOLD			PLATINUM	
HMO	<input type="checkbox"/> HMO A	<input type="checkbox"/> HMO A	<input type="checkbox"/> HMO E	<input type="checkbox"/> HMO A	<input type="checkbox"/> HMO G	<input type="checkbox"/> HMO N	<input type="checkbox"/> HMO A	<input type="checkbox"/> HMO H
	<input type="checkbox"/> HMO B	<input type="checkbox"/> HMO B	<input type="checkbox"/> HMO F	<input type="checkbox"/> HMO B	<input type="checkbox"/> HMO H	<input type="checkbox"/> HMO O	<input type="checkbox"/> HMO B	<input type="checkbox"/> HMO I
	<input type="checkbox"/> HMO C	<input type="checkbox"/> HMO C	<input type="checkbox"/> HMO G	<input type="checkbox"/> HMO C	<input type="checkbox"/> HMO I	<input type="checkbox"/> HMO P	<input type="checkbox"/> HMO C	<input type="checkbox"/> HMO J
		<input type="checkbox"/> HMO D		<input type="checkbox"/> HMO D	<input type="checkbox"/> HMO J	<input type="checkbox"/> HMO Q	<input type="checkbox"/> HMO D	<input type="checkbox"/> HMO K
				<input type="checkbox"/> HMO E	<input type="checkbox"/> HMO L		<input type="checkbox"/> HMO E	<input type="checkbox"/> HMO L
				<input type="checkbox"/> HMO F	<input type="checkbox"/> HMO M		<input type="checkbox"/> HMO F	<input type="checkbox"/> HMO M
						<input type="checkbox"/> HMO G	<input type="checkbox"/> HMO N	

D. ☐ PPO

Specific Health Plan: (select one benefit plan from the Metal Tier(s) selected in Section N)

	BRONZE	SILVER	GOLD
Anthem Blue Cross PPO	<input type="checkbox"/> PPO A* <input type="checkbox"/> PPO B*	<input type="checkbox"/> PPO C <input type="checkbox"/> PPO D	<input type="checkbox"/> PPO B <input type="checkbox"/> PPO C <input type="checkbox"/> PPO D* <input type="checkbox"/> PPO E*

*HSA Qualified High Deductible Plan

E. ☐ PPO

Lowest cost benefit plan in PPO: (select one benefit level from the Metal Tier(s) selected in Section N)

	BRONZE	SILVER	GOLD
Anthem Blue Cross PPO	<input type="checkbox"/> PPO A* <input type="checkbox"/> PPO B*	<input type="checkbox"/> PPO C <input type="checkbox"/> PPO D	<input type="checkbox"/> PPO B <input type="checkbox"/> PPO C <input type="checkbox"/> PPO D* <input type="checkbox"/> PPO E*

*HSA Qualified High Deductible Plan

F. ☐ Lowest cost PPO within the Metal Tier(s) selected.

G. ☐ Any HMO, EPO or PPO plan selected by employee.

H. ☐ Lowest cost HMO/EPO from a specific Metal Tier (select one Metal Tier): ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

I. ☐ Lowest cost PPO from a specific Metal Tier (select one Metal Tier): ☐ Bronze ☐ Silver ☐ Gold ☐ Platinum

(CONTINUED ON NEXT PAGE)

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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 (write 0 if none) OR \$ Combined amount for Employee and Dependents

OPTION 3 ☐ EMPLOYEE FIXED DOLLAR AMOUNT**STEP 1:** Enter the dollar amount(s) the employee will contribute toward

\$ Employee Cost \$ Additional for child(ren) *If you do not make an additional contribution for dependents enter "NA"*
\$ Additional for Spouse \$ Additional for Family

STEP 2: Apply contribution toward A or B**A. ☐ HMO & EPO** Specific Health Plan (select one benefit plan from the Metal Tier(s) selected in Section N)

	Anthem Blue Cross	Cigna + Oscar	Health Net		Kaiser Permanente	Sharp	Sutter Health Plus	United Healthcare		Western Health
BRONZE		<input type="checkbox"/> EPO C* <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E <input type="checkbox"/> EPO F	<input type="checkbox"/> HMO A		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B*			<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*
SILVER	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> EPO C <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E* <input type="checkbox"/> EPO F <input type="checkbox"/> EPO G*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D* <input type="checkbox"/> HMO E	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO E <input type="checkbox"/> HMO F <input type="checkbox"/> HMO G		<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*
GOLD	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> EPO C <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E <input type="checkbox"/> EPO F <input type="checkbox"/> EPO G	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D <input type="checkbox"/> HMO E	<input type="checkbox"/> HMO F <input type="checkbox"/> HMO G <input type="checkbox"/> HMO H <input type="checkbox"/> HMO I	<input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D <input type="checkbox"/> HMO E*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO D	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C*	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO F <input type="checkbox"/> HMO G <input type="checkbox"/> HMO H <input type="checkbox"/> HMO J	<input type="checkbox"/> HMO L <input type="checkbox"/> HMO M <input type="checkbox"/> HMO N <input type="checkbox"/> HMO O <input type="checkbox"/> HMO P <input type="checkbox"/> HMO Q	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO D*
PLATINUM	<input type="checkbox"/> HMO A	<input type="checkbox"/> EPO C <input type="checkbox"/> EPO D <input type="checkbox"/> EPO E <input type="checkbox"/> EPO F <input type="checkbox"/> EPO G	<input type="checkbox"/> HMO C <input type="checkbox"/> HMO D <input type="checkbox"/> HMO E <input type="checkbox"/> HMO F	<input type="checkbox"/> HMO G <input type="checkbox"/> HMO H <input type="checkbox"/> HMO I <input type="checkbox"/> HMO J	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C <input type="checkbox"/> HMO E <input type="checkbox"/> HMO G <input type="checkbox"/> HMO H	<input type="checkbox"/> HMO I <input type="checkbox"/> HMO J <input type="checkbox"/> HMO K <input type="checkbox"/> HMO L <input type="checkbox"/> HMO M <input type="checkbox"/> HMO N	<input type="checkbox"/> HMO A <input type="checkbox"/> HMO B <input type="checkbox"/> HMO C

* HSA Qualified High Deductible Plan

B. ☐ PPO

Specific Health Plan: →
(select one benefit plan from the Metal Tier(s) selected in Section N)

	BRONZE	SILVER	GOLD
Anthem Blue Cross PPO	<input type="checkbox"/> PPO A* <input type="checkbox"/> PPO B*	<input type="checkbox"/> PPO C <input type="checkbox"/> PPO D <input type="checkbox"/> PPO E*	<input type="checkbox"/> PPO B <input type="checkbox"/> PPO C <input type="checkbox"/> PPO D <input type="checkbox"/> PPO E

* HSA Qualified High Deductible Plan

OPTION 4 ☐ EMPLOYER DENTAL CONTRIBUTION

Enter the percentage amount you will contribute % for Employee (50% minimum required) % for Dependents (write 0 if none)

Applied toward (check one box only)

MetLife DHMO	SmileSaver DHMO	Ameritas PPO
<input type="checkbox"/> MET100 <input type="checkbox"/> MET185	<input type="checkbox"/> 1000 <input type="checkbox"/> 3000	<input type="checkbox"/> 3000 <input type="checkbox"/> 4000 <input type="checkbox"/> 3500 <input type="checkbox"/> 5000

Company Name

Group #

Authorized Group Contact Signature

(Person signing form must be authorized contact on record for CaliforniaChoice®)

Print Name

Date (MM/DD/YYYY)

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