CaliforniaChoice®
Your Health. Your Choice.®
721 South Parker, Suite 200, Orange, CA 92868
(800) 558-8003 • www.calchoice.com

Employer Change Request Form

Email: gpc@choiceadmin.com

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 | Extension # | 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.

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 | Title/Position

Remove Contact | Title/Position

☐ 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:

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, 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
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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CC 0564 10/2018 Eff. 1/1/2019

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

☐ F. ADD CHIRO*PLUS*

☐ 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 California*Choice*® 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 Buy-Up Dental Coverage*

☐ Remove Ortho from current Buy-Up Dental Coverage

*When adding Ortho coverage, please remember that there is a 24 month waiting period unless the group qualifies for waiver.

☐ N. CHANGE METAL TIER

Select **ONE** Metal Tier option to offer to your employees

Single Tier	☐ BRONZE	☐ SILVER	☐ GOLD	☐ PLATINUM
Tiered Choice	☐ BRONZE/SILVER	☐ SILVER/GOLD	☐ GOLD/PLATINUM	
Triple Tier Choice	☐ 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

RENEWAL ONLY (cont.)

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

☐ 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 I.

OPTION 1 ☐ PERCENTAGE OF COST

STEP 1: Enter the percentage amount you will contribute toward
STEP 2: Apply contribution toward A*, B*, C*, D, E, F or G
(*If no HMO plan available to Employee, contribution will be based on lowest cost PPO plan)

Employee Premium ☐ % (50% minimum required)
Dependent Premium ☐ % (write 0 if none)

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

B. ☐ **HMO, HSP, and EPO**

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

	Anthem Blue Cross	Health Net	Kaiser Permanente	Oscar	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE	☐ EPO A	☐ HSP A	☐ HMO A ☐ HMO C*	☐ EPO A* ☐ EPO B	☐ HMO A ☐ HMO B*	☐ HMO A ☐ HMO B*	☐ HMO B*	☐ HMO B ☐ HMO C* ☐ HMO D*
SILVER	☐ HMO A ☐ EPO A ☐ EPO B*	☐ HMO A ☐ HMO B ☐ HSP A	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D*	☐ EPO A* ☐ EPO B ☐ EPO C	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C*
GOLD	☐ HMO A	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D ☐ HMO E	☐ HMO A ☐ HMO B	☐ EPO A ☐ EPO B ☐ EPO C ☐ EPO D	☐ HMO A ☐ HMO B ☐ HMO D	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D*
PLATINUM	☐ HMO A	☐ HMO C ☐ HMO D ☐ HMO E	☐ HMO A ☐ HMO B	☐ EPO A ☐ EPO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B

* 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	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D ☐ HMO E	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D ☐ HMO E

D. ☐ **PPO**

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

	Anthem Blue Cross	Health Net	Kaiser Permanente	Oscar	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE								
SILVER	☐ PPO A ☐ PPO B							
GOLD	☐ PPO A ☐ PPO B ☐ PPO C ☐ PPO D							
PLATINUM								

E. ☐ **PPO**

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

	BRONZE	***SILVER***	***GOLD***		***PLATINUM***
PPO		☐ PPO A ☐ PPO B	☐ PPO A ☐ PPO B	☐ PPO C ☐ PPO D	

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

G. ☐ **Any HMO, HSP, EPO 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 (write 0 if none) **OR** $ ☐ Combined amount for Employee and Dependents

(CONTINUED ON NEXT PAGE)

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OPTION 3 ☐ EMPLOYEE FIXED DOLLAR AMOUNT

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

$ _____ Employee Cost $ _____ Additional for child(ren)

$ _____ Additional for Spouse $ _____ Additional for Family

If you do not make an additional contribution for dependents enter "NA"

STEP 2: Apply contribution toward A or B

A. ☐ **HMO, HSP, and EPO**

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

* HSA Qualified High Deductible Plan

	Anthem Blue Cross	Health Net	Kaiser Permanente	Oscar	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE	☐ EPO A	☐ HSP A	☐ HMO A ☐ HMO C*	☐ EPO A* ☐ EPO B	☐ HMO A ☐ HMO B*	☐ HMO A ☐ HMO B*	☐ HMO B*	☐ HMO B ☐ HMO C* ☐ HMO D*
SILVER	☐ HMO A ☐ EPO A ☐ EPO B*	☐ HMO A ☐ HMO B ☐ HSP A	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D*	☐ EPO A* ☐ EPO B ☐ EPO C	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO B ☐ HMO C*	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C*
GOLD	☐ HMO A	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D ☐ HMO E	☐ HMO A ☐ HMO B	☐ EPO A ☐ EPO B ☐ EPO C ☐ EPO D	☐ HMO A ☐ HMO B ☐ HMO D	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D	☐ HMO A ☐ HMO B ☐ HMO C ☐ HMO D*
PLATINUM	☐ HMO A	☐ HMO C ☐ HMO D ☐ HMO E	☐ HMO A ☐ HMO B	☐ EPO A ☐ EPO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B	☐ HMO A ☐ HMO B ☐ HMO C	☐ HMO A ☐ HMO B

B. ☐ **PPO**

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

	Anthem Blue Cross	Health Net	Kaiser Permanente	Oscar	Sharp	Sutter Health Plus	UnitedHealthcare	Western Health
BRONZE								
SILVER	☐ PPO A ☐ PPO B							
GOLD	☐ PPO A ☐ PPO B ☐ PPO C ☐ PPO D							
PLATINUM								

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)

☐ Prepaid 1000 ☐ PPO 3000 ☐ PPO 4000
☐ Prepaid 3000 ☐ PPO 3500 ☐ PPO 5000

Company Name _____ **Group #** _____

Authorized Group Contact Signature _____ **Print Name** _____ **Date (MM/DD/YYYY)** _____

(Person signing form must be authorized contact on record for California*Choice®)*

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