

Your Health. Your Choice.*

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

Employer Change Request Form

| Image: Contract in the group's new shifting address below: (Check here if billing address and street address are the same) Street City County State ZIP Code Check here if phone and/or fars # has not changed Phone # (XXX) XXX-XXXX Phone # (XXX) XXX-XXXX Extension # Fars # (XXX) XXX-XXXX Primary Contact Title/Position Title/Position Direct Phone # (XXX) XXX-XXXX Extension # E-mail Address Direct Phone # (XXX) XXX-XXXX Extension # E-mail Address Direct Phone # (XXX) XXX-XXXXX Extension # Title/Posi | Company Name | Group | # | |
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| E. ADD CHIRO <i>plus</i> | |

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)

F. ADD VOLUNTARY DENTAL 3000

*Complete the Voluntary Dental 3000 Application (Form # CC 0567)

G. ADD BUY-UP DENTAL

*Complete the Buy-up 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) | Participation Limitations: P.O.P. rules require that all participants in the plan be complexed by additional plants in the pla |
| 3. Plan # (usually 501) (If not indicated, 501 will be used) | 4. State of Incorporation (if applicable) | 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 |
| 5. Company Structure | | employees as defined by Tax Code, and therefore are ineligible to participate in the P.O.P. |
| 6. Premium payments may be elected for | Dental Other: | IMPORTANT: Read the information provided in the California <i>Choice®</i> Employer Optional Benefits Guide pertaining |
| 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. | to the Section 125 Premium Only Plan and the tax consequences. |

RENEWAL ONLY Changes below and on next page are <u>only</u> allowed at Renewal (Anniversary Date)

J. 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.

K. CHANGE HOURS OF ELIGIBILITY

From 30+ to 20+ hours per week

From 20+ to 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.

L. CHANGE METAL TIER

Select $\underline{\textbf{ONE}}$ Metal Tier option to offer to your employees

| Single Tier | BRONZE | SILVER | 🔲 GOLD | PLATINUM |
|-------------|--------|--------|--------|----------|
|-------------|--------|--------|--------|----------|

| Tiered Choice | BRONZE/SILVER | SILVER/GOLD | GOLD/PLATINUN |
|----------------------|---------------|-------------|---------------|
|----------------------|---------------|-------------|---------------|

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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| | **F | RENEWAL | | ** (cont.) | Changes | below are <u>only</u> | allowed at Re | newal (Anniver | sary Date) | |
|--|---|-------------|--------------------|----------------------------------|-------------------------|-----------------------|--|--|---|--|
| M. CHANGE PREMIUM CONTRIBUTION For medical contribution, please select Option 1, Option 2 or Option 3 ¹ If you wish to suppress contribution figures, please check Option 5. | | | | | | | | | | |
| 0 | PTION 1 🗌 PERC | ENTAGE O | F COST | | , | | | • | | |
| | STEP 1: Enter the percentage amount you will contribute toward Employee Premium % (50% minimum required) STEP 2: Apply contribution toward A*, B*, C*, D, E, F or G % (write 0 if none) (*If no HMO plan available to Employee, contribution will be based on lowest cost PPO plan) Dependent Premium % (write 0 if none) | | | | | | | | | |
| А. | Lowest cost HM | | | | | | <u>.</u> | | | |
| | | | | (-) | | | | | | |
| в. | | | Aetna | Anthem Blue Cross | Health Net | Kaiser Permanente | Sharp | Sutter Health Plus | UnitedHealthcare | Western Health HMO A* |
| | Specific Health Plan (select one benefit plan | BRONZE | ☐ НМО А ☐ НМО В | | HSP A | ☐ HMO B ☐ HMO C* | ☐ HMO A ☐ HMO B* ☐ HMO C* | ☐ HMO A ☐ HMO B* | ☐ HMO A ☐ HMO B* | |
| | from the Metal Tier(s) selected in Section L) | SILVER | ☐ НМО А ☐ НМО В | | HSP A | ☐ НМО В ☐ НМО С | ☐ НМО А ☐ НМО В | ☐ HMO A ☐ HMO B ☐ HMO C* ☐ HMO D* | ☐ HMO A ☐ HMO B ☐ HMO C* ☐ HMO D | ☐ HMO A ☐ HMO B ☐ HMO C* |
| | | GOLD | ☐ HMO A ☐ HMO B | | HMO A HMO B HSP A | ☐ НМО А ☐ НМО В | ☐ НМО А ☐ НМО В | ☐ HMO A ☐ HMO B ☐ HMO C | ☐ HMO A ☐ HMO B ☐ HMO C | ☐ НМО А ☐ НМО В |
| | *HSA Qualified High Deductible Plan | PLATINUM | П НМО А | П НМО А | П НМО А | 🗖 НМО А | ☐ НМО А ☐ НМО В | ☐ HMO A ☐ HMO C | ☐ HMO A ☐ HMO B ☐ HMO C | ☐ НМО А ☐ НМО В |
| . | HMO Lowest cost benefit plan level from the Metal Tier | | | it → | | НМО | BRONZE HMO A HMO B HMO C HMO D | SILVER HMO A HMO B HMO C HMO D | GOLD | PLATINUM HMO A HMO B HMO C |
| D. | ☐ PPO <u>Specific</u> → <u>Health Plan</u> | BRONZE | Aetna | Anthem Blue Cross | Health Net | Kaiser Permanente | Sharp | Sutter Health Plus | UnitedHealthcare | Western Health |
| | (select one benefit plan from the Metal | SILVER | | PPO A | | | | | | |
| | Tier(s) selected | GOLD | | PPO A PPO B PPO C PPO D | | | | | | |
| | | PLATINUM | | | | | | | | |
| E PPO BRONZE SILVER GOLD PLATINUM Lowest cost benefit plan in PPO (select one benefit plan in PPO (select one benefit plan in Section L) PPO PPO A PPO A PPO C Level from the Metal Tier(s) selected in Section L) PPO PPO B PPO D PPO D | | | | | | | | | | |
| F. | | | | | | | | | | |
| G. | Any HMO, HSP | , EPO or PI | PO plan s | elected by | y employe | e. | | | | |
| 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 | | | | | | | Employee | | | |
| | | | | (COI | NTINUED OI | N NEXT PAGE |) | | 8 | 072 |
| | (3 of 4) | | | | | | CC 0564B 4 | /2016 Eff. 7/1 | /2016 | |

| OPTION 3 E | MPLOY <u>EE</u> F | IXED DO | LLAR AMO | DUNT | | | | | | |
|--|-------------------|--------------------|--------------------|--------------------|--------------------|------------------------------------|--------------------|-----------------------------|----------------------|--|
| STEP 1: Enter the doll | ar amount(s) t | he employe | e will contrik | oute toward | | | | | | |
| | | | | | | | | | | |
| \$ | Emp | oloyee Cost | \$ | | / | Additional for c | hild(ren) | | | |
| \$ | Addi | itional for Sp | ouse \$ | | / | Additional for F | amily | | | |
| | | | lf ye | ou do not m | ake an additio | onal contribut | ion for depend | dents enter "NA" | | |
| STEP 2: Apply contrib | ution toward S | pecific Hea | Ith Plan (sel | ect one ben | efit plan from | the Metal Tier | r(s) selected in | n Section L) | | |
| HMO/HSP/EPO | | | Anthem | Health | Kaiser | | Sutter | | Western | |
| | | Aetna | Blue Cross | | Permanente | Sharp | Health Plus | UnitedHealthcare | Health | |
| | | П НМО А | Π ΕΡΟ Α | _ | 🗖 НМО В | П НМО А | 🗖 НМО А | П НМО А | ☐ HMO A* ☐ HMO B | |
| | BRONZE | 🗖 НМО В | EPO B* | HSP A | 🗖 нмо с* | □ HMO B* □ HMO C* | 🗖 НМО В* | П НМО В* | ☐ HMO C* ☐ HMO D* | |
| | | _ | | | | | П НМО А | П НМО А | | |
| | SILVER | □ HMO A □ HMO B | □ HMO A □ EPO A | HSP A | □ нмо в □ нмо с | ☐ НМО А ☐ НМО В | П нмо в | ☐ НМО В ☐ НМО С* | | |
| | | | | | | | | | HMO C* | |
| | GOLD | | | □ HMO A □ HMO B | П НМО А | П НМО А | ☐ НМО А ☐ НМО В | ☐ HMO A ☐ HMO B | | |
| | | П НМО В | EPO A* | HSP A | П НМО В | П нмо в | НМО С | П нмо с | П НМО В | |
| *HSA Qualified High Deductible Plan | PLATINUM | П НМО А | П НМО А | П НМО А | П нмо а | ☐ НМО А ☐ НМО В | □ нмо а □ нмо с | ☐ НМО А ☐ НМО В | ☐ НМО А ☐ НМО В | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | MPLOYER I | DENTAL (| CONTRIBU | TION | | | | | | |
| Enter the percentage amount you | | | mployee | ired) | | o for Dependen vrite 0 if none) | ts Prepaid | ed toward (check or 1000 | | |
| will contribute | | (50%1 | iniiniiniinii requ | | | ville o li fiorie) | | 3000 🔲 PPO 350 | 00 🔲 PPO 5000 | |
| | | | | | | | | | | |
| | UPPRESS C | | | | | | | | | |
| | UPPRESS C | | | | | | | | | |
| [†] 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. | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Commons Nome | | | | | | | | 0 | | |
| Company Name | | | | | | | | Group # | | |
| 1 | | | | | | | | | | |

Authorized Group Contact Signature

Print Name

Date (MM/DD/YYYY)

 $(Person \ signing \ form \ must \ be \ authorized \ contact \ on \ record \ for \ California Choice^{\circledast})$

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

