CALIFORNIA

Small Group Medical Plan Change Request Form

(For existing enrollments only)

UnitedHealthcare®

Effective Date: _____
(To be completed by Underwriting)

Instructions

Prior to requesting a different plan, please reference the Product Catalog that describes the plan you are considering. This guide details the benefits, copayments, and annual deductibles of the plans. The plan you choose must be a part of your employer's Small Group benefit package.

1. You, the employee, must complete this medical plan change request form. You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full and all signatures/dates must be completed; otherwise, this form may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. Type or print clearly in blue or black ink.

   Group Name/Group Number: _____

   Please indicate your current coverage/plan name: _____

1. Medical Coverage Selection – Check only one Medical Plan:

A. Choice of Coverage – Please change my coverage to:

Choice Simplified

Select Plus	15/20%	☐ AK-RV
Select Plus	2000/30%	☐ AK-RW
Select Plus HSA	6500/0%	☐ AK-RX
Core	15/20%	☐ AK-RY
Core	2000/30%	☐ AK-RZ
Core HSA	6500/0%	☐ AK-R1
Navigate	15/20%	☐ AK-SF
Navigate	2000/30%	☐ AK-SG
Navigate HSA	6500/0%	☐ AK-SH
Select Plus Direct	20/250/20%	☐ AK-R7
Select Plus Direct	20/750/20%	☐ AK-R8
Select Plus Direct	20/1000/20%	☐ AK-R9
Select Plus Direct	30/2000/30%	☐ AK-SA
Core Direct	20/250/20%	☐ AK-SB
Core Direct	20/750/20%	☐ AK-SC
Core Direct	20/1000/20%	☐ AK-SD
Core Direct	30/2000/30%	☐ AK-SE
Navigate Direct	20/250/20%	☐ AK-SN
Navigate Direct	20/750/20%	☐ AK-SO
Navigate Direct	20/1000/20%	☐ AK-SP
Navigate Direct	30/2000/30%	☐ AK-SQ
Signature	20-40/30%	☐ AK-QY
Signature	30-50/30%	☐ AK-QZ
Signature	30-50/30%/1000ded	☐ AK-Q1
Signature	45-65/40%/2000ded	☐ AK-Q2
Advantage	20-40/30%	☐ AK-Q4
Advantage	30-50/30%	☐ AK-Q5
Advantage	30-50/30%/1000ded	☐ AK-Q6
Advantage	45-65/40%/2000ded	☐ AK-Q7
Focus	20-40/30%	☐ AK-Q9
Focus	30-50/30%	☐ AK-RA
Focus	30-50/30%/1000ded	☐ AK-RB
Focus	45-65/40%/2000ded	☐ AK-RC
Alliance	20-40/30%	☐ AK-RE
Alliance	30-50/30%	☐ AK-RF
Alliance	30-50/30%/1000ded	☐ AK-RG
Alliance	45-65/40%/2000ded	☐ AK-RH
Alliance	30%/2000ded	☐ AK-RI
Alliance HSA	0%/6500ded	☐ AK-RJ
Non-Differential PPO	2000/30%	☐ AK-RU

Multi-Choice State

Core	15/10%	☐ AK-R2
Core	30/20%	☐ AK-R3
Core	45/2000/20%	☐ AK-R4
Core	75/6300/100%	☐ AK-R5
Core HSA	4500/40%	☐ AK-R6
Navigate	15/10%	☐ AK-SI
Navigate	30/20%	☐ AK-SJ
Navigate	45/2000/20%	☐ AK-SK
Navigate	75/6300/100%	☐ AK-SL
Navigate HSA	4500/40%	☐ AK-SM
Signature	15-40/10%	☐ AK-RK
Signature	30-55/20%	☐ AK-RL
Signature	45-75/20%/2000ded	☐ AK-RM
Focus	15-40/10%	☐ AK-RN
Focus	30-55/20%	☐ AK-RO
Focus	45-75/20%/2000ded	☐ AK-RP
Alliance	15-40/10%	☐ AK-RQ
Alliance	30-55/20%	☐ AK-RR
Alliance	45-75/20%/2000ded	☐ AK-RS
Alliance HSA	40%/4500ded	☐ AK-ST
Non-Differential PPO	2000/30%	☐ AK-RU

Group Name/Group Number: _____

2. Subscriber Information

B. Complete address portion ONLY if a recent change

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ Married	Social Security or I.D. Number
Street Address (P.O. Box not acceptable)			# of Dependents including Spouse	Spouse's Social Security or I.D. No.
City	State	ZIP Code	Home Phone No. ( )	Business Phone No. ( )
Occupation	Employer Name			No. of Hours Worked Per Week

3. Subscriber/Family Information

C. List yourself and all eligible family members requesting a change in coverage. If you select a UnitedHealthcare HMO, you must choose a Primary Care Physician for each member of your family. All family members must be in the same plan.

1	☐ Add ☐ Delete	Self	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
2	☐ Add ☐ Delete	Spouse	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
3	☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
4	☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
5	☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			

4. Signature Required for Terms and Conditions – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all pages of this form. A reproduction of this authorization shall be as valid as the original.

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.

Signature (Required)	Date (Required)
X	

Group Name/Group Number: _____

5. Signature Required for Binding Arbitration - Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. A reproduction of this authorization shall be as 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 UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE 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 HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature (Required)	Date (Required)
X	