CaliforniaChoice®
Your Health. Your Choice.®
www.calchoice.com

- Use blue or black ink pen
- Do not shrink this form

RENEWAL
Change Request Form

Fax completed form to (714) 558-8000
or for assistance call (800) 558-8003

1 Employee Information

Employee Last Name		Employee Social Security Number	
Employee First Name		Middle Initial	CaliforniaChoice® Group #
Street Address	Apt. #	City	
State	Zip Code	Home Telephone ( )	Company Name

Address listed is: ☐ Residential Address ☐ Mailing Address | ☐ Check here if new address

2 Adding/Cancelling A Spouse/Domestic Partner/Dependent

Complete this section to add/cancel dependent coverage. If adding dependents ages 19 to 24, please also complete the Student Verification Form.

Reason for Cancellation:

	Coverage Type	Last Name	First Name	Social Security Number	Birth Date (Month/Day/Year)	Full Time Student?	Dependent Disabled?	MEDICAL ONLY Primary Care Physician Name	ID #	✓ below if current doctor
EMPLOYEE										
❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision			— —	/ /			To change your physician or dentist, please contact your carrier. Refer to your handbook for carrier information.		
SPOUSE/DOMESTIC PARTNER										
❑ Spouse OR ❑ Domestic Partner ❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Male ❑ Female	— —	/ /					❑
CHILDREN										
❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Son ❑ Daughter	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No			❑
❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Son ❑ Daughter	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No			❑
❑ Add† ❑ Cancel	❑ Medical ❑ Dental ❑ Voluntary Vision		❑ Son ❑ Daughter	— —	/ /	❑ Yes ❑ No	❑ Yes ❑ No			❑

NOTE: If Last Name of spouse/child(ren) is different from Employee's Last Name, please give brief explanation:

†As I am adding my dependent(s), and 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 above enrolling dependents, 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: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a 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.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all CaliforniaChoice® benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through CaliforniaChoice program providers thereafter.

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. If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.

I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements.

PLEASE READ & SIGN THIS FORM!

Employee Name _____ **Group Number** _____

3 Health Plan & Medical Benefit Design Change/Add

(CHECK ONE) ❑ **ADD** ❑ **CHANGE**

*Indicate **NEW** benefit design you are requesting:*

HMO

Blue Shield	Health Net	Kaiser Permanente	Sharp Health Plan	Western Health Advantage
❑ Cal*Choice*® HMO 15	❑ Cal*Choice* HMO 15	❑ Cal*Choice* HMO 15	❑ Cal*Choice* HMO 15	❑ Cal*Choice* HMO 15
❑ Cal*Choice* HMO 25	❑ Cal*Choice* HMO 25	❑ Cal*Choice* HMO 25	❑ Cal*Choice* HMO 25	❑ Cal*Choice* HMO 25
❑ Cal*Choice* HMO 25 Value	❑ Cal*Choice* HMO 25 Value	❑ Cal*Choice* HMO 30	❑ Cal*Choice* HMO 30	❑ Cal*Choice* HMO 30
❑ Cal*Choice* HMO 30	❑ Cal*Choice* HMO 30	❑ Cal*Choice* HMO 40	❑ Cal*Choice* HMO 40	❑ Cal*Choice* HMO 40
❑ Cal*Choice* HMO 40	❑ Cal*Choice* HMO 30 Value			❑ Cal*Choice* HMO 40 Value
❑ Cal*Choice* HMO 40 Value	❑ Cal*Choice* HMO 40			
	❑ Cal*Choice* HMO 40 Value			
	❑ Elect Open Access			

Please select a Primary Care Physician (not needed for Kaiser Permanente, PPO Enrollees or members changing benefit level only) for each currently enrolled family member. Do not list those already provided in section 2. If adding dependents ages 19 to 24, please also complete the Student Verification Form.

Last Name	First Name	PCP (HMO only) Name	ID #	*Please verify that doctor is still affiliated with above plan!*	✓ below if current doctor
YOU					
					❑
DEPENDENTS					
					❑
					❑
					❑
					❑
					❑

PPO

❑ PPO 750 ❑ PPO 2400 ❑ HSA 2400*
❑ PPO 1000 ❑ HSA 1500* ❑ Active Choice℠ 500

PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE

**HSA-Qualified High Deductible Health Plan*

4 Dental Benefit Design Change/Add

(CHECK ONE) ❑ **ADD** ❑ **CHANGE**

❑ Dental Plan FDH 100
❑ Dental Plan 1000†
❑ Dental Plan 3000†
❑ Voluntary Dental Plan 3000†
❑ Dental Plan 3500
❑ Dental Plan 4000
❑ Dental Plan 5000

† If electing any plan above, please select a dentist

Dentist's Name _____ ID # _____ ❑ Check if current dentist

5 Voluntary Vision Add

❑ *Check this box to add Voluntary Vision (fill out section 2 to add dependents)*

PLEASE READ & SIGN THIS FORM!

Your LEGAL Acknowledgement *(Read, Sign & Date Below)*

By submitting this signed application, I agree and understand that the health plan I have chosen through the California*Choice*® program shall automatically have a lien on any payment of monies from any source, for services rendered in conjunction with an injury caused by the acts or omissions of a third party.

I agree for myself and my dependents to be bound by the benefits, copays, deductibles, exclusions, limitations and other terms of the health plan's small group contract.

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the California*Choice* program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize California*Choice* and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months from the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

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

- I am either actively, permanently working for the employer and considered eligible by my employer because I work either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 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 are unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partners.

I understand that the above statements are subject to audit at any time and **agree** to provide California*Choice* with any and all information necessary to prove the above statements.

I understand that false statements and/or failure **to provide the information upon request will cause the termination of all** California*Choice* benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through California*Choice* program providers thereafter.

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.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that I myself and my dependents have met all of the eligibility requirements listed on the fourth page of this application.

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

HEALTH NET ENROLLEES:

BINDING ARBITRATION AGREEMENT: Subject to the terms of the Plan Contract or Insurance Policy (which may prohibit mandatory arbitration of certain disputes if the Plan Contract or Insurance Policy is subject to ERISA, 29 U.S.C. section 1001, et seq.), I, the Employee, understand and agree that any and all disputes or disagreements between me (including any of my enrolled family members or heirs or personal representatives) and the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, regarding the construction, interpretation, performance or breach of the Plan Contract or Insurance Policy, or regarding other matters relating to or arising out of my Health Net Entities, the Safeguard Entities and/or the Fidelity Entities membership, whether stated in tort, contract or otherwise, and whether or not other parties such as health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities, are giving up their constitutional right to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Health Net Entities, the Safeguard Entities and/or the Fidelity Entities involving claims for medical malpractice are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Plan Contract or Insurance Policy. My signature below indicates that I agree to submit any dispute to binding arbitration.

KAISER FOUNDATION HEALTH PLAN ENROLLEES:

Arbitration Agreement: I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs, relatives or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

SHARP ENROLLEES:

It is understood that any dispute or controversy between the Member and the Plan arising out of or in connection with this Group Agreement, excluding a claim of medical malpractice, will be determined by submission to final and binding arbitration in accordance with the provisions of Article XIII of this Group Agreement, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Group Agreement, by entering into it, are giving up their constitutional right to have any such dispute or controversy decided in a court of law before a jury, and instead are accepting the use of arbitration.

WESTERN HEALTH ADVANTAGE ENROLLEES:

Arbitration Agreement: I agree and understand that any and all disputes between myself (including any heirs or assigns) and Western Health Advantage, including 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 Small Claims Court cases and claims subject to ERISA, 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 California law provides for judicial review of arbitration proceedings. The parties, including any heirs or assigns, 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.

Employee **SIGN HERE FOR MEDICAL, DENTAL, OR VISION COVERAGE:** Print Name Date:

My signature acknowledges both the applicable arbitration disclosure of the HMO I selected in Section 3 and my decision to enroll in the medical, dental, or vision coverage that I selected in Sections 3, 4 & 5.

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Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that MUST be met:
New Spouse	If marriage occurred before the 16th of the month, coverage begins on date of marriage† If marriage occurred on the 16th of the month or after, coverage begins on the first of month following date of marriage	■ New spouse must be legally married to the employee
New Baby, New Stepchild, Adopted Child, Non-Temporary Legal Ward, and Dependent Children	If birth/date of placement occurred before the 16th of the month, coverage begins on the date of their 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	■ Born to, a step-child of, adopted by, or non-temporary legal ward of the employee ■ Financially dependent upon the employee per IRS guidelines ■ Unmarried or not involved in a domestic partnership ■ Under age 19–unless disabled, disability occurring prior to age 25–or a full-time student and under age 25 **Please note:** A dependent child enrolled as a full-time student will not lose medical coverage because of a break in the school calendar or because he or she takes a medical leave of absence from school, for up to 12 months or until the date which the coverage is scheduled to terminate under the terms and conditions of the plan, whichever comes first. Physician Certification will be required and must be submitted within 30 days prior to the medical leave from school if the leave is foreseeable. If the leave is not foreseeable, the request must be submitted within 30 days of the medical leave from school. **Disabled Dependents:** Dependents who are incapable of self-support because of a 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, re-verification of disability will be required annually. 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	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 Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue or a signed affidavit for opposite sex and under age 62 domestic partnerships.	For a Domestic Partner to qualify, Employee and Domestic Partner must: ■ Share a common residence ■ Neither is married under either statutory, common law or part of another domestic partnership ■ Both be 18 years of age or older ■ Share an intimate and committed relationship ■ Agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship ■ Both be mentally competent ■ Not related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify California*Choice*® immediately upon termination of domestic partnership Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership. **Employee and Domestic Partner must meet all requirements listed in order to be eligible for enrollment**
Children of Domestic Partner	See Domestic Partner above	Domestic Partner must meet requirements listed above, and Children of Domestic Partner must be: ■ Born to, a step-child of, adopted by, or non-temporary legal ward of the employee or domestic partner ■ Financially dependent upon the employee or domestic partner ■ Unmarried or not involved in a domestic partnership ■ Under age 19–unless disabled, disability occurring prior to age 25–or a full-time student and under age 25 **Please note:** A dependent child enrolled as a full-time student will not lose medical coverage because of a break in the school calendar or because he or she takes a medical leave of absence from school, for up to 12 months or until the date which the coverage is scheduled to terminate under the terms and conditions of the plan, whichever comes first. Physician Certification will be required and must be submitted within 30 days prior to the medical leave from school if the leave is foreseeable. If the leave is not foreseeable, the request must be submitted within 30 days of the medical leave from school. **Disabled Dependents:** Dependents who are incapable of self-support because of a 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, re-verification of disability will be required annually. Verification of eligibility will occur annually at the child's birthday **Dependents must meet all requirements listed in order to be eligible for enrollment**

† Although coverage may become effective at any time of the month based on date of marriage/domestic partnership/birth/adoption, full premium for increased coverage will be assessed as described in the Effective Dates column located above.

CC 0311C 2/2009