PacAdvantage

EMPLOYEE/MEMBER OPEN ENROLLMENT CHANGE FORM

(PacAdvantage Pool Only)

Please complete this form and return it to your employer. If you seek services prior to receiving your ID card from the plan, you may be required to pay out-of-pocket costs for care received. These out-of-pocket costs may be reimbursed by the plan if they are part of your covered benefits.

A. REQUIRED INFORMATION (for all changes)

Group number

Name of employer

Salutation

☐ Mr. ☐ Mrs. ☐ Ms.

Employee first name

Employee last name

M.I.

Suffix (Jr., Sr., etc.)

Date of birth

B. IN THIS SECTION, COMPLETE ONLY THE INFORMATION THAT HAS CHANGED

Home phone number

Physical home address

Apartment

City

State

Zip

Marital status

☐ Single ☐ Married ☐ Registered Domestic Partnership ☐ Non-registered Domestic Partnership

PacAdvantage reserves the right to request documents that verify the validity of a non-registered domestic partnership. See Summary of Employee Rules and Procedures available at www.pacadvantage.org for details.

Mailing address

Apartment

City

State

Zip

E-mail address

C. IF YOU WISH TO CHANGE THE COVERAGE CHOICE FOR YOUR BENEFIT PACKAGE, PLEASE INDICATE BELOW

*If you are making **no changes** to your medical, dental, vision or chiropractic/acupuncture benefit plan selections, check here ☐ and go to section H.*

COVERAGE CHOICE

☐ Employee only ☐ Employee and spouse ☐ Employee and State of CA registered domestic partner ☐ Employee and non-registered domestic partner

☐ Employee and child(ren) ☐ Family

☐ **Waiving optional (dental, vision, chiropractic/acupuncture) benefits coverage for dependents under age 2. Must be checked if enrolling a dependent under age 2 in medical, or coverage for optional benefits will be included for dependent.**

If you wish to add dependents to your benefit package, you must also complete an employee application form available at www.pacadvantage.org. Please mark "ADD DEPENDENT" at the top of the form. If you are disenrolling a dependent, please complete Member Termination Form."

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Group number _____ Employee Last Name _____

D. MEDICAL PLAN SELECTION

Are you refusing coverage? No ☐ Yes ☐ (If so, please complete a Refusal of Coverage Form and refer to the Employee Summary of Rules and Procedures available at www.pacadvantage.org or through your employer.)

If you are making no changes to your medical coverage, check here ☐ and go to section E. Please submit any primary care physician changes directly to your chosen medical plan. Please obtain the Carrier/Plan Number from your Employee Rate Illustration.

If you are continuing with the same medical plan carrier but changing benefit option, please complete this section:

SELECTED MEDICAL PLAN CARRIER NAME _____ **PLAN NUMBER** _____

CO-PAYMENT/DEDUCTIBLE OPTION (HMO only): ☐ Preferred ☐ Plus ☐ Standard
Please submit information regarding any change to your primary care physician directly to your chosen medical plan carrier.

If you are changing medical plan carriers, please complete this section:

SELECTED MEDICAL PLAN CARRIER NAME _____ **PLAN NUMBER** _____

CO-PAYMENT/DEDUCTIBLE OPTION (HMO only): ☐ Preferred ☐ Plus ☐ Standard

PRIMARY CARE PHYSICIAN'S LAST NAME _____ PRIMARY CARE PHYSICIAN'S FIRST NAME _____

Are you a current patient? ☐ Yes ☐ No

DEPENDENT'S NAME _____ DEP. PRIMARY CARE PHYSICIAN'S LAST NAME _____ DEP. PRIMARY CARE PHYSICIAN'S FIRST NAME _____

_____ _____ _____

E. DENTAL PLAN SELECTION (if applicable)

SELECTED DENTAL PLAN NAME _____ **PLAN NUMBER** _____

Dentist/Dental group ID number _____ Are you a current patient? ☐ Yes ☐ No

Dentist's last name (required for prepaid dental plans) _____ First name _____

(To verify provider availability, contact selected medical/dental carrier.)

Dependent's name _____ Dependent's dentist's last name _____ Dependent's dentist's first name _____

_____ _____ _____

Prior dental coverage name

_____

Start date __ __ / __ __ / __ __ __ __ End date __ __ / __ __ / __ __ __ __

☐ Private insurance ☐ Medi-Cal ☐ None (Uninsured) ☐ Other _____

F. VISION PLAN SELECTION (if applicable)

SELECTED VISION PLAN NAME _____ **PLAN NUMBER** _____

VISION CO-PAYMENT OPTION ☐ Preferred ☐ Plus

G. CHIROPRACTIC/ACUPUNCTURE PLAN SELECTION (if applicable)

SELECTED CHIROPRACTIC/ACUPUNCTURE PLAN NAME _____ **PLAN NUMBER** _____

CHIROPRACTIC/ACUPUNCTURE CO-PAYMENT OPTION ☐ Plus ☐ Standard

H. SIGNATURE OF EMPLOYEE REQUIRED

Signature _____ Date signed __ __ / __ __ / __ __ __ __