CaliforniaChoice
Your Health. Your Choice.®

721 South Parker, Suite 200
Orange, CA 92868
(800) 558-8003
FAX (714) 558-8000

Employer Change Request Form

Group Name ____________________ CaliforniaChoice Group # ________

OPEN ENROLLMENT ONLY

Changes below are **only** allowed at Open Enrollment (Anniversary Date)

❑ PREMIUM CONTRIBUTION CHANGE

Please select ONE option from items 1-3

*Note: Dependent contributions are optional for employers. †If you wish to suppress contribution figures, please check option 5.

OPTION 1 ❑ PERCENTAGE OF COST

STEP 1: Enter the percentage amount you will contribute toward:

Employee Premium: ___________% (50% minimum required)   *Dependent Premium: ___________% (write 0 if none)

STEP 2: Apply contribution toward one HMO, PPO or ANY Plan Option (A, B, or C)

A. ❑ **HMO** →
- ❑ Lowest cost plan in HMO benefit level
- ❑ Highest cost plan in HMO benefit level
- ❑ All plans in HMO benefit level
- ❑ Specific Health Plan: ______________________ in benefit level: → ❑ 10 ❑ 25 ❑ 40

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

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

C. ❑ Any HMO 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

OR $ ________ Combined amount for Employee and *Dependents

OPTION 3 ❑ EMPLOYEE FIXED DOLLAR AMOUNT

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

$ ______ Employee Cost $ ______ *Additional for Spouse $ ______ *Additional for Child(ren) $ ______ *Additional for Family

STEP 2: Apply contribution toward one HMO or PPO Option (A or B):

A. ❑ **HMO** →
- ❑ Lowest cost plan in HMO benefit level
- ❑ Specific Health Plan: ______________________ in benefit level: → ❑ 10 ❑ 25 ❑ 40

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

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

OPTION 4 ❑ EMPLOYER DENTAL CONTRIBUTION

Enter the percentage amount you will contribute:

__________ % for Employee (50% minimum required)   **Applied toward:** Dental Plan Number ________________

__________ % for *Dependents

OPTION 5 ❑ †SUPPRESS CONTRIBUTION

Suppressing contributions will result in only full premium amounts reflected on invoices and quotes. **Contribution must still be at least 50% of lowest cost plan for each employee.**

❑ ADD/CHANGE CHIRO PLUS TO:

❑ Chiropractic Only ❑ Chiro & Acupuncture

❑ CHANGE WAITING PERIOD TO:

❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days ❑ 365 days

All employees currently in the waiting period must either enroll at Open Enrollment or be subject to the new waiting period selected.

Group Plan Administrator Signature ____________________   Print Name ____________________   Date ____________

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OPEN ENROLLMENT *(continued)* Changes below are **only** allowed at Open Enrollment (Anniversary Date)

❑ 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.

OFF ANNIVERSARY Changes below may be made at any time once a year

❑ ADD CHIRO PLUS

❑ Chiropractic Only ❑ Chiro & Acupuncture

❑ ADD SECTION 125

A one time $100 Enrollment Fee must be submitted if enrolling during Open Enrollment or 90 days following (increases to $250 if elected after 90 days following Open Enrollment)

1. Name of Company President, Principal, or Partners: ______________________

2. Name of Corporate Secretary: (if applicable) ______________________

3. Plan Number: ____________ (usually 501)

4. State of Incorporation (if applicable): ______________________

5. Company Structure:

❑ Corporation ❑ S Corporation ❑ Partnership ❑ Sole Proprietorship ❑ LLC ❑ Other__________________

6. Premium payments may be elected for: ❑ Medical ❑ Dental ❑ Other: ________________

7. Last day of first Plan year: ______/______/______ 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.

❑ ADD LIFE INSURANCE

Requirements:

1. 100% of eligible employees must participate. Employee Enrollment Applications (**Form CC 0310**) must be submitted by each employee with Sections A, C, & E completed.

2. A reconciled current quarter DE6 must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, T=terminated, S=seasonal, etc.)

Guaranteed Issue Life Amounts:

2-5 eligible employees = up to $5,000	**11-25 eligible employees = up to $25,000**
6-10 eligible employees = up to $10,000	**26-50 eligible employees = up to $50,000**

Groups wishing to apply for Life amounts higher than the guaranteed issue amounts above must be medically underwritten. Please contact our Member Services Department for additional information.

3. Select a Life amount: ______________________

❑ ADD DENTAL 100

Effective date is the 1st day of the month following request

❑ ADD VOLUNTARY DENTAL 3000

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

❑ ADD BUY-UP DENTAL

***Complete the Buy-up Dental Application (Form # CC 0566)**

❑ ADD VOLUNTARY VISION

***Complete the Voluntary Vision Application (Form # CC 0285)**

______________________ Group Name

______________________ Date

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

______________________ Group Plan Administrator Signature

______________________ Print Name