

Covered California for Small Business Change Request Form for Employees



**COVERED CALIFORNIA
SMALL BUSINESS**

Check here if changes are to be effective at renewal.

Fax completed form to (949) 809-3264

Mail to Covered California at P.O. Box 7010, Newport Beach, CA 92658

Check to Decline Coverage
You must also read and sign the Declination Acknowledgement on Page 4.

For assistance call (855) 777-6782

EMPLOYER INFORMATION

Employer name & address

Employer phone number
() -

Covered California for Small Business (CCSB) Group #

REASON FOR CHANGE (CHECK ALL THAT APPLY)

EFFECTIVE DATE
MM/DD/YYYY

QUALIFYING
EVENT DATE

REASON FOR CHANGE (CHECK ALL THAT APPLY)	EFFECTIVE DATE MM/DD/YYYY	QUALIFYING EVENT DATE
<input type="checkbox"/> GROUP OPEN ENROLLMENT MUST BE RECEIVED PRIOR TO RENEWAL DATE	CHANGE WILL BE EFFECTIVE AT RENEWAL	CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> NEW HIRE INDICATE DATE MEMBER IS ELIGIBLE FOR COVERAGE		
<input type="checkbox"/> PART-TIME TO FULL-TIME EMPLOYMENT CHANGE INDICATE DATE COVERAGE WILL BE EFFECTIVE		
<input type="checkbox"/> LOSS OR GAIN OF OTHER COVERAGE INDICATE DATE OF EFFECTIVE CHANGE AND PROVIDE LETTER FROM CARRIER OR EMPLOYER		
<input type="checkbox"/> NAME CHANGE/ADDRESS CHANGE INDICATE EFFECTIVE DATE OF CHANGE		
<input type="checkbox"/> MARRIAGE OR DOMESTIC PARTNER ADDITION INDICATE DATE OF MARRIAGE OR DOMESTIC PARTNER DECLARATION		
<input type="checkbox"/> BIRTH, ADOPTION, GUARDIANSHIP, FOSTER CARE OR QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) OF DEPENDENT CHILD INDICATE DATE OF BIRTH, ADOPTION, GUARDIANSHIP, FOSTER CARE OR QUALIFIED MEDICAL CHILD SUPPORT ORDER		
<input type="checkbox"/> DEPENDENT TERMINATION INDICATE EFFECTIVE DATE OF CHANGE		

PLEASE PROVIDE THE DETAIL REGARDING YOUR CHANGE(S) IN THE RESPECTIVE SECTIONS THAT FOLLOW.

EMPLOYEE INFORMATION

1. First name, Middle name, Last name & Suffix

2. Date of Birth | Month | Day | Year

3. Social Security Number or Tax ID Number | Sex

NEW EMPLOYEE Complete information below. **EXISTING EMPLOYEE** Complete only information that has changed.

4. HOME address | 5. Apartment or suite number

6. City | 7. State | 8. ZIP code | 9. County

10. MAILING address | 11. Apartment or suite number

12. City | 13. State | 14. ZIP code | 15. County

16. Email address (OPTIONAL) | 17. Phone number Cell Home Work | 18. Other phone number Cell Home Work

19. What is the preferred method of communication? Mail Email Phone

CHECK HERE IF NAME CHANGE OR CORRECTION

20. New First Name

21. New Last Name

NEED HELP WITH YOUR FORM? Contact your employer or your employer's Covered California Certified Insurance Agent with questions, visit **CoveredCA.com** or call us at (855) 777-6782. Para obtener una copia de este formulario en Español, llame (855) 777-6782.

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Employee Name	Employer Name	CCSB Group #
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COMPLETE THIS SECTION TO CANCEL COVERAGE, ADD DEPENDENTS OR CHANGE PLANS

IMPORTANT! Plan changes are allowed during renewal and for employees who experience a qualifying event (i.e. newborn).

- **CANCELLATIONS** of coverage will take effect on the **LAST DAY** of the month **AFTER RECEIPT** of your request by Covered California. Cancellations at renewal will take effect on the group's renewal date.
- **ADDITIONS (QUALIFYING EVENT):** Please see your employer for effective date guidelines based on qualifying event.
- **ADDITIONS (AT RENEWAL):** Coverage will be effective on the group's renewal date.
- **CHANGES (AT RENEWAL):** If making any plan changes, please list all covered dependents.

This form must be received by Covered California **NO LATER THAN 30 DAYS** after the event takes place if outside renewal.

EMPLOYEE	LAST NAME (FAMILY NAME)		FIRST NAME		MI	SSN / TAX ID #	SEX
	BIRTHDATE MM/DD/YYYY		NAME OF HEALTH PLAN SELECTED				
	<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL		NAME OF DENTAL PLAN SELECTED (OPTIONAL)				
REASON						LAST DAY OF COVERAGE	


 Please see the following page for the available CCSB health and dental plans to choose from.

SPOUSE OR DOMESTIC PARTNER	LAST NAME (FAMILY NAME)		FIRST NAME		MI	SSN / TAX ID #	SEX
	BIRTHDATE MM/DD/YYYY		ARE YOU A DOMESTIC PARTNER?	IF YES, IS THE PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DENTAL PLAN SELECTED	
	<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL		REASON				LAST DAY OF COVERAGE

CHILD	LAST NAME (FAMILY NAME)		FIRST NAME		MI	SSN / TAX ID #	SEX
	BIRTHDATE MM/DD/YYYY		IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER?		DENTAL PLAN SELECTED		
	<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL		REASON				LAST DAY OF COVERAGE


ADDRESS (IF DIFFERENT THAN EMPLOYEE)	STREET	CITY	STATE	ZIP
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CHILD	LAST NAME (FAMILY NAME)		FIRST NAME		MI	SSN / TAX ID #	SEX
	BIRTHDATE MM/DD/YYYY		IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER?		DENTAL PLAN SELECTED		
	<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL		REASON				LAST DAY OF COVERAGE

ADDRESS (IF DIFFERENT THAN EMPLOYEE)	STREET	CITY	STATE	ZIP
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CHILD	LAST NAME (FAMILY NAME)		FIRST NAME		MI	SSN / TAX ID #	SEX
	BIRTHDATE MM/DD/YYYY		IS CHILD BOTH DISABLED AND 26 YEARS OR OLDER?		DENTAL PLAN SELECTED		
	<input type="checkbox"/> ADD <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL		REASON				LAST DAY OF COVERAGE

ADDRESS (IF DIFFERENT THAN EMPLOYEE)	STREET	CITY	STATE	ZIP
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Employee name	Employer Name	CCSB Group #
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NEW HEALTH AND DENTAL PLAN CHOICES

IMPORTANT! Plan changes are only allowed at renewal. However, employees who experience a qualifying event (e.g. acquire a new dependent) are able to change their coverage outside of the renewal period.

NOTE: Infertility benefits are available to employer groups when an Employer elects to provide this benefit during open enrollment or renewal periods. If an employer with 20 or more full time employees elects to provide infertility benefits, all plans offered will include the this coverage.

If an employer with less than 20 full time employees elects to provide infertility benefits, only PPO and EPO plans will include this coverage. Infertility benefits will not be included in HMO plans for groups with less than 20 full time employees.

Plan selection varies by region. Please check with your employer for the list of available health plans in your area.

Health Plan	METAL TIER			
	Bronze	Silver	Gold	Platinum
Blue Shield	<input type="radio"/> Bronze 60 PPO 6300/65 + Child Dental	<input type="radio"/> Silver 70 PPO 2250/50 + Child Dental <input type="radio"/> Trio Silver 70 HMO 2250/55 + Child Dental	<input type="radio"/> Gold 80 PPO 350/25 + Child Dental <input type="radio"/> Trio Gold 80 HMO 250/35 + Child Dental	<input type="radio"/> Platinum 90 PPO 0/15 + Child Dental <input type="radio"/> Trio Platinum 90 HMO 0/20 + Child Dental
Health Net	<input type="radio"/> Bronze 60 PPO 6300/65 + Child Dental <input type="radio"/> Bronze 60 HDHP PPO 7000/0% + Child Dental Alt	<input type="radio"/> Silver 70 HDHP PPO 1400/40% + Child Dental Alt <input type="radio"/> Silver 70 PPO 2250/50 + Child Dental <input type="radio"/> Silver 70 PPO 2250/55 + Child Dental Alt	<input type="radio"/> Gold 80 PPO 0/30 + Child Dental Alt <input type="radio"/> Gold 80 PPO 1000/30 + Child Dental Alt <input type="radio"/> Gold 80 PPO 350/25 + Child Dental	<input type="radio"/> Platinum 90 PPO 0/15 + Child Dental
Kaiser Permanente	<input type="radio"/> Bronze 60 HMO 6300/65 + Child Dental <input type="radio"/> Bronze 60 HMO 5400/60 + Child Dental Alt <input type="radio"/> Bronze 60 HDHP HMO 7000/0% + Child Dental	<input type="radio"/> Silver 70 HMO 2250/55 + Child Dental <input type="radio"/> Silver 70 HDHP HMO 2500/20% + Child Dental <input type="radio"/> Silver 70 HMO 1650/55 Alt + Child Dental Alt <input type="radio"/> Silver 70 HMO 2600/55 + Child Dental Alt <input type="radio"/> Silver 70 HMO 2100/55 + Child Dental Alt	<input type="radio"/> Gold 80 HMO 250/35 + Child Dental <input type="radio"/> Gold 80 HMO 1000/40 + Child Dental Alt <input type="radio"/> Gold 80 HMO 0/30 + Child Dental Alt <input type="radio"/> Gold 80 HDHP HMO 1600/15% + Child Dental Alt	<input type="radio"/> Platinum 90 HMO 0/20 + Child Dental <input type="radio"/> Platinum 90 HMO 0/10 + Child Dental Alt
Sharp	<input type="radio"/> Performance Bronze 60 HMO 6300/65 + Child Dental <input type="radio"/> Premier Bronze 60 HDHP HMO 7000/0% + Child Dental	<input type="radio"/> Premier Silver 70 HMO 2250/55 + Child Dental <input type="radio"/> Performance Silver 70 HMO 2250/50 + Child Dental <input type="radio"/> Premier Silver 70 HDHP HMO 2500/20% + Child Dental	<input type="radio"/> Performance Gold 80 HMO 350/25 + Child Dental <input type="radio"/> Premier Gold 80 HMO 250/35 + Child Dental	<input type="radio"/> Performance Platinum 90 HMO 0/15 + Child Dental <input type="radio"/> Premier Platinum 90 HMO 0/20 + Child Dental

*For health plans that do not include Child Dental, employees have the option to elect a standalone pediatric dental plan. Dependent children are eligible for Pediatric Dental coverage up to age 19.

Dental Plans	PEDIATRIC DENTAL PLANS	FAMILY DENTAL PLANS**
California Dental Network	<input type="radio"/> Children's Dental HMO	<input type="radio"/> Family Dental HMO
Delta Dental	<input type="radio"/> Children's Dental HMO <input type="radio"/> Children's Dental PPO	<input type="radio"/> Family Dental HMO <input type="radio"/> Family Dental PPO
Dental Health Services		<input type="radio"/> Family Dental HMO
Liberty Dental		<input type="radio"/> Family Dental HMO

** Family dental plans offer both adult only and adult plus child coverage.

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SIGN THE FORM

COVERED CALIFORNIA BINDING ARBITRATION AGREEMENT

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including, for premises liability, relating to the coverage for, or delivery of, services or items, or, if I select a Kaiser Permanente 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), 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 in the Health Plan's coverage document, which is available for my review.

I am signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Signature of Employee	Date (mm/dd/yyyy)
Employer Name	

! **STOP!** ONLY complete and sign below if you are declining coverage.

DECLINATION ACKNOWLEDGEMENT

I am declining medical coverage for (check all that apply):

- Self
 Spouse / Domestic Partner
 Child(ren) Name(s) _____

I am declining dental coverage for (check all that apply):

- Self
 Spouse / Domestic Partner
 Child(ren) Name(s) _____

Reason for declining coverage (choose one):

- Covered by spouse's / domestic partner's group plan
 Covered by individual policy
 Covered by Tricare
 Covered by Medicare
 Covered by Medi-Cal
 Covered by Other: _____
 Coverage is too expensive. (You may want to contact Covered CA at www.coveredca.com for help in understanding the available options and financial assistance in the Covered Ca Individual Marketplace)

I acknowledge that the coverage available to me has been explained to me by my employer and I have the right to enroll in the coverage offered. I have voluntarily decided not to enroll myself and/or my eligible dependent(s). By declining this coverage I acknowledge that I and/or my eligible dependents will have to wait until my employer's next open enrollment period to enroll or change coverage, unless eligible for a special enrollment period through a qualifying event.

Signature of Employee	Date (mm/dd/yyyy)
Employer Name	

CERTIFIED INSURANCE AGENT INFORMATION

Please tell us the Certified Insurance Agent who assisted you with your Covered California for Small Business health coverage.

Certified Insurance Agent Name	Email	Phone Number
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I did not receive assistance from a Certified Insurance Agent.

RETURN YOUR COMPLETED, SIGNED FORM TO YOUR EMPLOYER

Your employer will send us your form, and we will contact you if we need additional information or to let you know your request for changes to your coverage have been approved.

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