Covered California for Small Business
Change Request Form for Employees 2017

COVERED CALIFORNIA | FOR SMALL BUSINESS

☐ Check here if changes are to be effective at renewal.

Fax completed form to (949) 809-3264 or
mail to Covered California at P.O. Box 7010, Newport Beach, CA 92658
For assistance call (855) 777-6782

EMPLOYER INFORMATION

Employer name & address

Employer phone number ( ) -	Covered California for Small Business (CCSB) CASE ID #

REASON FOR CHANGE (CHECK ALL THAT APPLY)

		EFFECTIVE DATE MM/DD/YYYY
☐ GROUP OPEN ENROLLMENT		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐ NEW HIRE	INDICATE DATE COVERAGE WILL BE EFFECTIVE	
☐ PART-TIME TO FULL-TIME EMPLOYMENT CHANGE	INDICATE DATE COVERAGE WILL BE EFFECTIVE	
☐ LOSS OR GAIN OF OTHER COVERAGE	INDICATE DATE OF EFFECTIVE CHANGE AND PROVIDE LETTER FROM CARRIER OR EMPLOYER	
☐ NAME CHANGE/ADDRESS CHANGE	INDICATE EFFECTIVE DATE OF CHANGE	
☐ MARRIAGE OR DOMESTIC PARTNER ADDITION	INDICATE DATE OF MARRIAGE OR DOMESTIC PARTNER DECLARATION	
☐ 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	
☐ OTHER, PLEASE DESCRIBE:		

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.

continued next page ➡

Employee name	Employer Name	CCSB Case ID#

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.

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		Please see the following page for the available CCSB health and dental plans to choose from.	
☐ ADD ☐ CHANGE ☐ CANCEL	NAME OF DENTAL PLAN SELECTED (OPTIONAL)			
REASON			LAST DAY OF COVERAGE	

SPOUSE OR DOMESTIC PARTNER

LAST NAME (FAMILY NAME)	FIRST NAME	MI	SSN / TAX ID #	SEX
BIRTHDATE MM/DD/YYYY	ARE YOU A DOMESTIC PARTNER? ☐ YES ☐ NO	IF YES, IS THE PARTNERSHIP REGISTERED WITH THE STATE OF CALIFORNIA? ☐ YES ☐ NO	DENTAL PLAN SELECTED	
☐ ADD ☐ CHANGE ☐ 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? ☐ YES ☐ NO	DENTAL PLAN SELECTED		
☐ ADD ☐ CHANGE ☐ CANCEL	REASON		LAST DAY OF COVERAGE	
ADDRESS (IF DIFFERENT THAN EMPLOYEE) STREET	CITY	STATE	ZIP	

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? ☐ YES ☐ NO	DENTAL PLAN SELECTED		
☐ ADD ☐ CHANGE ☐ CANCEL	REASON		LAST DAY OF COVERAGE	
ADDRESS (IF DIFFERENT THAN EMPLOYEE) STREET	CITY	STATE	ZIP	

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? ☐ YES ☐ NO	DENTAL PLAN SELECTED		
☐ ADD ☐ CHANGE ☐ CANCEL	REASON		LAST DAY OF COVERAGE	
ADDRESS (IF DIFFERENT THAN EMPLOYEE) STREET	CITY	STATE	ZIP	

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continued next page

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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.

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	○ Bronze 60 PPO 6300/75 + Child Dental	○ Silver 70 PPO 2000/45 + Child Dental ○ Silver 70 HMO 2000/45 + Child Dental	○ Gold 80 PPO 0/30 + Child Dental ○ Gold 80 HMO 0/30 + Child Dental	○ Platinum 90 PPO 0/15 + Child Dental ○ Platinum 90 HMO 0/15 + Child Dental
CCHP	○ Bronze 60 HMO 6300/75 + Child Dental	○ Silver 70 HMO 2000/45 + Child Dental	○ Gold 80 HMO 0/30 + Child Dental	○ Platinum 90 HMO 0/15 + Child Dental
Health Net	○ Bronze 60 PPO 6300/75 + Child Dental ○ PPO Bronze HSA (Alt)	○ Silver 70 PPO 2000/45 + Child Dental ○ Silver 70 EPO 2000/20 + Child Dental Alternate ○ PPO Silver Value (Alt)	○ Gold 80 PPO 0/30 + Child Dental ○ Gold 80 EPO 1300/20 + Child Dental Alternate ○ PPO Gold Value (Alt)	○ Platinum 90 PPO 0/15 + Child Dental
Kaiser Permanente	○ Bronze 60 HMO 6300/75 ○ Bronze 60 HDHP 4800/40%	○ Silver 70 HMO 2000/45 ○ Silver 70 HMO 1000/50 Alternate ○ Silver 70 HDHP HMO 2000/20%	○ Gold 80 HMO 0/30 ○ Gold 80 HMO 500/35 Alternate	○ Platinum 90 HMO 0/15 ○ Platinum 90 HMO 0/10 Alternate
Sharp	○ Bronze 60 HMO 6300/75 + Child Dental Network 2 ○ Bronze 60 HDHP 4800/40% + Child Dental Network 1	○ Silver 70 HMO 2000/45 + Child Dental Network 2 ○ Silver 70 HMO 2000/45 + Child Dental Network 1 ○ Silver 70 HDHP HMO 2000/20% + Child Dental Network 1	○ Gold 80 HMO 0/30 + Child Dental Network 2 ○ Gold 80 HMO 0/30 + Child Dental Network 1	○ Platinum 90 HMO 0/15 + Child Dental Network 2 ○ Platinum 90 HMO 0/15 + Child Dental Network 1
Western Health Advantage	○ Bronze 60 HMO 6300/75 + Child Dental ○ Bronze 60 HDHP HMO 4800/40% + Child Dental ○ Bronze 60 HDHP HMO 6500/0 + Child Dental Alternate	○ Silver 70 HMO 2000/45 + Child Dental ○ Silver 70 HDHP HMO 2000/20% + Child Dental	○ Gold 80 HMO 0/30 + Child Dental	○ Platinum 90 HMO 0/15 + 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**
Access Dental	○ Children's Dental HMO	○ Family Dental HMO
Delta Dental	○ Children's Dental HMO ○ Children's Dental PPO	○ Family Dental HMO ○ Family Dental PPO
Liberty Dental	○ Children's Dental HMO	○ Family Dental HMO
Dental Health Services	○ Children's Dental HMO	○ Family Dental HMO
Premier Access Dental	○ Children's Dental PPO	○ Family Dental PPO
California Dental Network	○ Children's Dental HMO	○ Family Dental HMO

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

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continued next page ➡

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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

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.

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
J. Stephen Downey	Steve@jsdowney.com	6192975888

☐ **I did not receive assistance from a Certified Insurance Agent.**

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