

EMPLOYEES: USE THIS FORM TO UPDATE PERSONAL INFORMATION OR TO ADD/CANCEL COVERAGE

Change Request Form



DO NOT USE THIS FORM TO CHANGE PHYSICIAN OR DENTIST



PLEASE RETURN COMPLETED FORM TO HEALTH PLAN ADMINISTRATOR



1 Employee Information

PLEASE PRINT USING BLACK OR BLUE INK

Employee Last Name										Employee Social Security Number									
Employee First Name										Middle Initial					CaliforniaChoice Group #				

EMPLOYER/COMPANY NAME

2 Name/Address Change

COMPLETE THIS SECTION ONLY IF REPORTING A NAME/ADDRESS CHANGE

TYPE OF CHANGE: NAME ADDRESS (IF ADDRESS CHANGE **REQUIRES** A CHANGE OF HEALTH PLAN, PLEASE COMPLETE A NEW ENROLLMENT APPLICATION AND ATTACH TO THIS FORM.)

LAST NAME	FIRST	MIDDLE INITIAL	
ADDRESS	CITY	STATE	ZIP CODE
HOME TELEPHONE ()	WORK TELEPHONE (INCLUDE EXTENSION, IF ANY) ()		

3 Coverage Change

COMPLETE ONLY IF YOU ARE AN ACTIVE EMPLOYEE WHO WANTS TO ADD OR CANCEL COVERAGE

THIS FORM MUST BE RECEIVED BY CALIFORNIA CHOICE BENEFIT ADMINISTRATORS NO LATER THAN 31 DAYS AFTER THE EVENT TAKES PLACE IN ORDER TO QUALIFY FOR COVERAGE.

CANCELLATIONS OF COVERAGE WILL TAKE EFFECT ON THE LAST DAY OF THE MONTH AFTER RECEIPT OF YOUR REQUEST BY CALIFORNIA CHOICE BENEFIT ADMINISTRATORS. **ADDITIONS** OF COVERAGE WILL BECOME EFFECTIVE ON THE FIRST DAY OF THE MONTH PRECEDING EVENT (MARRIAGE, BIRTH, ADOPTION). *PLEASE ATTACH A COPY OF MARRIAGE CERTIFICATE OR LEGAL DOCUMENTS AS APPLICABLE.

THOSE SELECTING DEPENDENT COVERAGE FOR BOTH MEDICAL AND DENTAL MUST ENROLL THE SAME DEPENDENTS. (IF SELECTING EMPLOYEE ONLY MEDICAL, ANY DENTAL DEPENDENT COVERAGE IS ACCEPTABLE. IF SELECTING EMPLOYEE ONLY DENTAL, ANY MEDICAL DEPENDENT COVERAGE IS ACCEPTABLE.)

IF APPLICABLE: DATE OF MARRIAGE/DIVORCE IF ADDING/CANCELLING SPOUSE: IF CHILD CUSTODY, ENTER DATE OF ADOPTION/GUARDIANSHIP: REASON FOR CANCELLATION:

**ATTACH COPY OF MARRIAGE CERTIFICATE* **ATTACH COPY OF LEGAL DOCUMENTATION*

	Coverage Type	Last Name	First Name	Sex (M/F)	Social Security Number	Birth Date (Mo/Day/Yr)	Full Time Student?	Dependent Disabled?	Primary Care Physician Name	Primary Care Physician ID #	✓ below if current doctor
EMPLOYEE	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Cancel										
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner*	*Affidavit required if adding a Domestic Partner to coverage										
CHILDREN	<input type="checkbox"/> Add <input type="checkbox"/> Cancel						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Add <input type="checkbox"/> Cancel						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> Add <input type="checkbox"/> Cancel						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

LIFE INSURANCE BENEFICIARY CHANGE SECTION ON REVERSE SIDE

CALIFORNIA CHOICE STAFF USE

EMPLOYEE #

EFFECTIVE DATE

PLAN CODE

PROCESSED

By signing this document, I authorize my employer to deduct from my wages any additional premium contributions required as a result of the above changes.

I also authorize any physician, practitioner, hospital, medical care institution, insurance company, or other organization, institution, person or employer that has any records or knowledge of care, treatment or advice of me, my spouse or my children to give such information to CaliforniaChoice Benefit Administrators or its representatives. This authorization remains in effect as long as necessary to evaluate my application and/or process claims for me and my covered dependents. A photographic copy of this authorization shall be viewed as valid as the original.

I certify that the above information is true and complete to the best of my knowledge.

EMPLOYEE SIGNATURE

DATE

PLEASE RETAIN A COPY OF THIS REQUEST FOR YOUR RECORDS

CC 0500 07/2000

PLEASE REMEMBER TO COMPLETE SECTION 1 ON REVERSE SIDE OF THIS FORM
BEFORE MAILING FORM BACK TO CALIFORNIA CHOICE.

4 Life Insurance Beneficiary Change

COMPLETE ONLY IF YOU WISH TO CHANGE THE EXISTING BENEFICIARY ON YOUR LIFE INSURANCE

I hereby revoke any previous designation of beneficiary and settlement provisions and make the following beneficiary designation with respect to any insurance payable at my death under the group plan (including any Group Life Insurance or Group Accidental Death and Dismemberment Insurance):

Primary Beneficiary Name(s):			Date of Birth (Mo/Day/Yr)	Relationship to You (i.e. spouse, friend, child)	*Percentage
Last Name	First Name	M.I.			
			/ /		
			/ /		
			/ /		
			/ /		

†Secondary Beneficiary Name(s):			Date of Birth (Mo/Day/Yr)	Relationship to You (i.e. spouse, friend, child)	*Percentage
Last Name	First Name	M.I.			
			/ /		
			/ /		
			/ /		
			/ /		

*If you are listing more than one Beneficiary or Contingent Beneficiary, please enter the percentage of the proceeds that each individual should receive.

Unless otherwise provided, if more than one primary beneficiary is designated, the primary beneficiary or primary beneficiaries living at the death of the employee shall be entitled to the insurance, equally if more than one. †However, if the designation provides for primary and secondary beneficiaries, no secondary beneficiary or secondary beneficiaries shall be entitled to any part of such insurance if any primary beneficiary is living at the death of the employee.

If there is no designated beneficiary living at the death of the employee, the insurance will be paid in accordance with the terms of the plan.

The right to change this designation is reserved to the employee under the terms of the plan.

SPOUSE SIGNATURE (Required if beneficiary is someone other than spouse)

DATE

EMPLOYEE SIGNATURE

DATE

NOTE: This change will be considered to become effective on the day it is received by CaliforniaChoice.

CaliforniaChoice Staff Use Only

CaliforniaChoice processed your requested beneficiary change on:

/ /

PLEASE RETAIN THIS COPY WITH YOUR LIFE INSURANCE CERTIFICATE BOOKLET.