

**Group Name** \_\_\_\_\_ **CaliforniaChoice® Group #**

**A. CHANGE ADDRESS/PHONE/FAX** *Please list the group's new billing address below:*  
(  Check here if billing address and street address are the same)

Group's new **billing** address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Group's new **street** address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check here if phone and/or fax number has not changed  
Please list group's new phone and/or fax number: Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

**B. ADD/CHANGE CONTACT** *Please add the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the group.*

**Primary Contact** \_\_\_\_\_ Title/Position \_\_\_\_\_  
Direct Line \_\_\_\_\_ Email \_\_\_\_\_

**Additional Contact** \_\_\_\_\_ Title/Position \_\_\_\_\_  
Direct Line \_\_\_\_\_ Email \_\_\_\_\_

*Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:*

Remove Contact \_\_\_\_\_ Title/Position \_\_\_\_\_  
Remove Contact \_\_\_\_\_ Title/Position \_\_\_\_\_

**C. ADD LIFE INSURANCE** *Groups wishing to apply for Life amounts higher than the guaranteed issue amounts below must be medically underwritten. Please contact our Customer Service Center for more information.*

**Requirements:**

- 100% of eligible employees (whether enrolling or waiving medical) must enroll for life coverage. Employee Enrollment Applications (Form CC 0310) must be submitted by each employee with Sections A, C, & F completed.
- A reconciled DE-6 must be submitted with all employees accounted for (i.e. E=eligible, PT=part-time, T=terminated, S=seasonal, etc.)
- 100% employer-paid premiums

<input type="checkbox"/> <b>OPTION 1: Flat Amount</b> <b>Select a Flat amount for all employees:</b>  Amount \$: <input type="text"/>	<b>← CHOOSE ONE OPTION ONLY →</b> Guaranteed Issue Amounts for both Options			<input type="checkbox"/> <b>OPTION 2: Scheduled Amount</b> <b>Select up to 4 amounts with the highest being NO MORE THAN 2.5X the lowest.</b> (Amounts must be in increments of \$5000)
	<b>Eligible Employees</b>	<b>Minimum</b>	<b>Maximum</b>	
	2-5	\$5,000	\$5,000	
	6-10	\$5,000	\$10,000	
	11-25	\$5,000	\$25,000	
	25-50	\$5,000	\$50,000	
	<b>*Employees must fall under classification to qualify for specified amount →</b>			
	# of eligible employees: <input type="text"/>			
	<b>Life Amount</b>	<b>Employee Classification*</b> (i.e. management, executives, etc.)		
	\$ _____	_____		
	\$ _____	_____		
	\$ _____	_____		
	\$ _____	_____		

▼▼▼▼ CHIROPRACTIC/ACUPUNCTURE, DENTAL AND VISION CHANGES MAY ONLY BE MADE ONCE A YEAR ▼▼▼▼

**D. ADD CHIROPPLUS**  Chiropractic Only  Chiro & Acupuncture

**E. ADD DENTAL 100** **Effective date is the 1st day of the month following request**

To add the following benefits as an option for your employees, complete the forms indicated below (Login at www.calchoice.com to download forms)

**F. ADD VOLUNTARY DENTAL 3000** **\*Complete the Voluntary Dental 3000 Application (Form # CC 0567)**

**G. ADD BUY-UP DENTAL** **\*Complete the Buy-up Dental Application (Form # CC 0566)**

**H. ADD VOLUNTARY VISION** **\*Complete the Voluntary Vision Application (Form # CC 0285)**

**I. ADD SECTION 125\*** **\*A one time \$100 Enrollment Fee must be submitted**

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  LLC  
 Sole Proprietorship  Partnership  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 CaliforniaChoice® Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Group Name

CaliforniaChoice® Group #

\_\_\_\_\_

\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_

**\*\*RENEWAL ONLY\*\*** Changes below are **only** allowed at Renewal (Anniversary Date)

**J. 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 (select one from list): **→**

Carrier	HMO 15	HMO 25	HMO 25 Value	Elect Open Access	HMO 30	HMO 30 Value	HMO 40	HMO 40 Value
Blue Shield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Net	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Western Health Advantage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Value Plans are available for contribution benefit level selection

- B.  **PPO:**  750  1000  2400  HSA 1500\*\*  HSA 2400\*\*  Active Choice<sup>SM</sup> 500
- PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE      \*\*HSA-Qualified High Deductible Health Plan*

C.  Any HMO or PPO plan selected by employee

**OPTION 2**  **EMPLOYER FIXED DOLLAR AMOUNT**

Enter the dollar amount(s) you will contribute \$ \_\_\_\_\_ for Employee  
toward any plan selected by the 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: \_\_\_\_\_
- Highest cost plan in HMO benefit level: \_\_\_\_\_
- All plans in HMO benefit level: \_\_\_\_\_
- Specific Health Plan (select one from list): **→**

Carrier	HMO 15	HMO 25	HMO 25 Value	Elect Open Access	HMO 30	HMO 30 Value	HMO 40	HMO 40 Value
Blue Shield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Net	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kaiser Permanente	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Western Health Advantage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Value Plans are available for contribution benefit level selection

- B.  **PPO:**  750  1000  2400  HSA 1500\*\*  HSA 2400\*\*  Active Choice<sup>SM</sup> 500
- PPO PLAN AVAILABILITY WILL BE BASED ON GROUP ELIGIBILITY AND MAY BE SUBJECT TO CHANGE      \*\*HSA-Qualified High Deductible Health Plan*

**OPTION 4**  **EMPLOYER DENTAL CONTRIBUTION**

Enter the percentage amount you will contribute: \_\_\_\_\_ % for Employee (50% minimum required)  
\_\_\_\_\_ % for \*Dependents      **Applied toward Dental Plan Number:** \_\_\_\_\_

**OPTION 5**  **SUPPRESS CONTRIBUTION**

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

**K. 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 Renewal or be subject to the new waiting period selected.

**L. 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.

Group Name

Date

Group Plan Administrator Signature (Person signing form must be authorized contact on record for CaliforniaChoice)

Print Name