

We will send you booklets containing benefit information for your new plan.
Please provide a booklet to each of your employees.
Fill in all areas below using **black ink**.

Customer information		
Company name	Customer ID	
Company contact	Enrollment unit	
Contact phone number ¹	Fax number ¹	E-mail ¹

Plan options
<p>This <i>Plan Change Request</i> form is used for changing your health plan, adding or deleting a dental plan, adding or deleting a chiropractic benefit, or changing your new hire waiting period. Plan upgrades are allowed at your renewal. Plan downgrades are subject to management approval. If you wish to offer multiple plans, please fill out the <i>Multiple Plan Offering Plan Change Request</i> form to switch to this option.</p> <p>Please make the selected changes effective _____ 1, 2011. (month)</p> <p>Contractual changes cannot be made effective during the 120 days before your anniversary date.</p>

Plan options	Dental plan options ⁵	Chiropractic options ⁵
<input type="checkbox"/> Please switch my plan to the following plan: Copayment plans <input type="checkbox"/> \$50 plan <input type="checkbox"/> \$30 plan <input type="checkbox"/> \$20 plan <input type="checkbox"/> \$15 plan <input type="checkbox"/> \$5 plan Deductible HMO plans <input type="checkbox"/> \$40/\$2,000 plan <input type="checkbox"/> \$30/\$1,500 plan <input type="checkbox"/> \$30/\$1,000 plan HSA-qualified deductible HMO plans <input type="checkbox"/> \$30/\$3,000 plan with HSA <input type="checkbox"/> \$0/\$2,700 plan with HSA <input type="checkbox"/> \$0/\$2,000 plan with HSA Deductible HMO plans with HRA^{2,3} <input type="checkbox"/> \$30/\$2,500 plan with HRA <input type="checkbox"/> \$30/\$1,500 plan with HRA POS plan^{3,4} <input type="checkbox"/> \$35 plan PPO insurance plans^{3,4} <input type="checkbox"/> \$40/\$2,500 plan with HSA <input type="checkbox"/> \$40/\$1,000 plan	<input type="checkbox"/> Please add or delete a dental plan: Delta Dental Premium <input type="checkbox"/> Plan C <input type="checkbox"/> Plan E <input type="checkbox"/> Plan D <input type="checkbox"/> Plan E with Ortho ⁶ Delta Dental <input type="checkbox"/> PPO D 1500 <input type="checkbox"/> PPO E 1000 <input type="checkbox"/> PPO E 1500 DeltaCare <input type="checkbox"/> DeltaCare 10A <input type="checkbox"/> DeltaCare 13B <input type="checkbox"/> Discontinue plan	<input type="checkbox"/> Please add or delete a chiropractic/acupuncture option: <input type="checkbox"/> Chiropractic benefit – \$15/20 visits combined <input type="checkbox"/> Chiropractic/Acupuncture benefit – For \$40/\$1000 PPO plan only – \$15/20 visits combined <input type="checkbox"/> Discontinue benefit
		Waiting period <input type="checkbox"/> Please change my new hire waiting period to the first of the month following: <input type="checkbox"/> Date of hire <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days The waiting period can only be shortened at annual renewal or at original group enrollment.

For more information, call **1-800-790-4661**. Group administrators, press 2.
Southern California brokers, press 3. Northern California brokers, press 4.

Mail to: Kaiser Permanente – Small Business, 393 E. Walnut St. (BRBK), Pasadena, CA 91188

Company name_____
Customer ID**Required signature**

By signing this form, I acknowledge that changing my plan may increase my rates and that I am responsible for the additional premium.

Authorized company signer (Please print name.)_____
Title**X**_____
Signature_____
Date**Kaiser Permanente approval**_____
Kaiser Permanente authorization_____
Title**X**_____
Signature_____
Date

It may take up to two billing cycles for the plan change to be reflected on your bill.

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¹By giving us your contact information, you agree to be contacted by a Kaiser Permanente representative by phone, fax, or e-mail.

²Employer must fund at least 25 percent of the subscriber's deductible for the \$30/\$1,500 Deductible HMO Plan with HRA and at least 40 percent of the subscriber's deductible for the \$30/\$2,500 Deductible HMO Plan with HRA.

³Deductible plans with HRA, POS plan, and PPO plans require additional forms to be completed. Call 1-800-790-4661.

⁴For your group to be eligible for the \$35 POS Plan, the \$40/\$1,000 PPO Plan, or the \$40/\$2,500 PPO Plan with HSA Option, you must have Kaiser Permanente as your sole carrier, and the plan must be offered with at least one copayment or deductible HMO plan as part of a multiple plan offering. If you include a Kaiser Permanente Insurance Company (KPIC) PPO or POS plan in your multiple plan offering, at least 70 percent of all employees enrolled in the Health Plan must be enrolled in a copayment or deductible HMO plan, and combined enrollment in KPIC medical plans must not exceed 30 percent.

⁵Dental and chiropractic options are only available when purchased with a health plan. These must be purchased at original group enrollment or at group's annual renewal.

⁶At least 10 or more subscribers are needed to enroll the group in Dental Plan E with Orthodontics.

The copayment plans, HSA-qualified deductible HMO plans, deductible HMO plans, deductible HMO plans with HRA, and the in-network portion of the point-of-service (POS) plan are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the PPO plan and the out-of-network portion of the POS plan as well as the Delta Dental of California dental plans. The chiropractic benefit is administered by American Specialty Health Plans of California, Inc. The chiropractic/acupuncture benefit is administered by Private Healthcare Systems.