

Employer Change Request Form

Group Name <input style="width:95%;" type="text"/>	Group # <input style="width:100%; height:20px;" type="text"/>
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****RENEWAL ONLY**** Changes below are only allowed at Renewal (Anniversary Date)

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 4.†

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, POS, PPO, Indemnity, HDHP* or ANY Plan Option (A, B, C, D, E or F)

- | |
|---|
| A. <input type="checkbox"/> HMO 10 <input type="checkbox"/> HMO 30 <input type="checkbox"/> HMO 20/\$1,000 |
| B. <input type="checkbox"/> POS 20/\$1,000 <input type="checkbox"/> POS 30/\$1,500 |
| C. <input type="checkbox"/> PPO 30/\$500 <input type="checkbox"/> PPO HSA 2200** |
| D. <input type="checkbox"/> Indemnity |
| E. <input type="checkbox"/> HDHP 1900** <input type="checkbox"/> HDHP 2700** |
| F. <input type="checkbox"/> Any plan selected by employee |

**HSA-Qualified High Deductible Health Plan

OPTION 2 **EMPLOYER FIXED DOLLAR AMOUNT**

Enter the dollar amount(s) you will contribute toward any plan selected by the employee:

\$ _____ for Employee **OR** \$ _____ Combined amount for Employee and Dependents*
 \$ _____ for Dependents*

OPTION 3 **EMPLOYER DENTAL CONTRIBUTION**

Enter the percentage amount you will contribute:

_____ % for Employee (50% minimum required) **Applied toward:** DHMO 200 PPO/FFS 1000
 _____ % for Dependents* DHMO 250 PPO/FFS 1500

OPTION 4 **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.**

CHANGE WAITING PERIOD TO: Date of Hire 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.

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.

ADD DENTAL Employees will make their elections on the Renewal Change Request Form (Form # KP 0311)

Enter the percentage amount you will contribute:

_____ % for Employee (50% minimum required) **Applied toward:** DHMO 200 PPO/FFS 1000
 _____ % for Dependents* DHMO 250 PPO/FFS 1500

Note: Dependent contributions are optional for employers.*

(Continued on other side)

Group Plan Administrator Signature _____ Print Name _____ Date _____

RENEWAL (continued) Changes below are only allowed at Renewal (Anniversary Date)

<input type="checkbox"/> ADD LIFE INSURANCE	AIG Employee Benefit Solutions												
<p>Requirements: 100% of eligible employees must participate. Employee Enrollment Applications (Form KP 0310*) must be submitted by each employee with Sections A, D (life portion) and E completed.</p> <p>CHOOSE EITHER OPTION 1 OR OPTION 2</p> <p><input type="checkbox"/> OPTION 1: Flat Amount Select a Flat amount for all employees:</p> <p>1. Amount \$: <input style="width: 80px;" type="text"/></p> <p>2. # of eligible employees: <input style="width: 80px;" type="text"/></p>	<p>Products underwritten by AIG Life Insurance Company Wilmington, DE A member company of American International Group, Inc. Policy Form Series G-LAD-40000 et al.</p> <p><input type="checkbox"/> OPTION 2: Scheduled Amount Select up to 4 amounts with the highest being NO MORE THAN 2.5 X the lowest. (highest amount ok in increments of \$5000)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="background-color: black; color: white;">Life Amount</th> <th style="background-color: black; color: white;">Employee Classification* <small>(i.e. management, administrative, etc.) Specific job titles will be required for each class</small></th> </tr> <tr><td style="height: 20px;">\$ _____</td><td>_____</td></tr> <tr><td style="height: 20px;">\$ _____</td><td>_____</td></tr> <tr><td style="height: 20px;">\$ _____</td><td>_____</td></tr> <tr><td style="height: 20px;">\$ _____</td><td>_____</td></tr> </table>	Life Amount	Employee Classification* <small>(i.e. management, administrative, etc.) Specific job titles will be required for each class</small>	\$ _____	_____	\$ _____	_____	\$ _____	_____	\$ _____	_____		
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\$ _____	_____												
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<p>Guaranteed Issue Amounts available for both Options</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: black; color: white;">Eligible Employees</th> <th style="background-color: black; color: white;">Minimum</th> <th style="background-color: black; color: white;">Maximum</th> </tr> </thead> <tbody> <tr><td style="text-align: center;">2-9</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$25,000</td></tr> <tr><td style="text-align: center;">10-24</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$50,000</td></tr> <tr><td style="text-align: center;">25-50</td><td style="text-align: center;">\$10,000</td><td style="text-align: center;">\$75,000</td></tr> </tbody> </table> <p style="text-align: center; background-color: black; color: white; padding: 2px;">Amounts in between available in increments of \$5000</p> <p>100% of all eligible employees (whether enrolling or waiving medical) must enroll for life coverage.</p> <p>*Employees must fall under classification to qualify for specified amount →</p>		Eligible Employees	Minimum	Maximum	2-9	\$10,000	\$25,000	10-24	\$10,000	\$50,000	25-50	\$10,000	\$75,000
Eligible Employees	Minimum	Maximum											
2-9	\$10,000	\$25,000											
10-24	\$10,000	\$50,000											
25-50	\$10,000	\$75,000											

OFF RENEWAL

<input type="checkbox"/> CHANGE ADDRESS/PHONE/FAX	<p><i>Please list the group's new billing address below:</i> <input type="checkbox"/> Check here if billing address and street address are the same)</p> <p>Group's new billing address:</p> <p>Street _____ City _____ State _____ Zip _____</p> <p>Group's new street address:</p> <p>Street _____ City _____ State _____ Zip _____</p> <p><input type="checkbox"/> Check here if phone and/or fax number has not changed</p> <p>Please list group's new phone and/or fax number: Phone number _____ Fax number _____</p>
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<input type="checkbox"/> ADD/CHANGE CONTACT	<p><i>Please add the individual(s) listed below as the primary/additional contact(s). Only authorized contacts may obtain confidential information regarding the group.</i></p> <p>Primary Contact _____ Title/Position _____</p> <p>Direct Line _____ Email _____</p> <p>Additional Contact _____ Title/Position _____</p> <p>Direct Line _____ Email _____</p> <p><i>Please remove the contacts listed below as they are no longer authorized to obtain confidential information on the group:</i></p> <p>Remove Contact _____ Title/Position _____</p> <p>Remove Contact _____ Title/Position _____</p>
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<input type="checkbox"/> ADD SECTION 125	<p>*A one time \$100 Enrollment Fee must be submitted</p> <p>1. Name of Company President, Principal, or Partners: _____</p> <p>2. Name of Corporate Secretary: (if applicable) _____</p> <p>3. Plan Number: _____ (usually 501)</p> <p>4. State of Incorporation (if applicable): _____</p> <p>5. Company Structure: <input type="checkbox"/> Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Other _____</p> <p>6. Premium payments may be elected for: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Other: _____</p> <p>7. Last day of first Plan year: _____ / _____ / _____ (Approximately 364 days after the effective date of coverage) Subsequent plan years will be the 12 month period following this date.</p>
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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 Kaiser Permanente Choice Solution Employer Optional Benefits Guide pertaining to the Section 125 Premium Only Plan and the tax consequences.

Group Name _____ Group Plan Administrator Signature _____

Date _____ Print Name _____