

Change Request Form

- **EMPLOYEES: USE THIS FORM TO UPDATE PERSONAL INFORMATION OR TO ADD/CANCEL COVERAGE**
- **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		Group #		

2 Name/Address Change

COMPLETE THIS SECTION ONLY IF REPORTING A NAME/ADDRESS CHANGE

EMPLOYER/COMPANY NAME

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

LAST NAME	FIRST	MIDDLE INITIAL	HOME TELEPHONE ()
ADDRESS	CITY	STATE	ZIP CODE

3 Coverage Change

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

THIS FORM MUST BE RECEIVED BY CHOICE 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 CHOICE Administrators. **Additions** of coverage will become effective on the **first day** of the month **preceding event** (marriage, birth, adoption/legal ward).
 *Please attach a copy of marriage license and/or certificate, proof of birth (birth certificate, announcement) or legal documents as applicable.

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: Reason for Cancellation:
 *Attach copy of marriage license and/or certificate *Attach copy of legal documentation

Coverage Type	Last Name	First Name	Sex	Social Security Number	Birth Date (Month/Day/Year)	Full Time Student?	Dependent Disabled?
EMPLOYEE							
<input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /		
<input type="checkbox"/> Spouse OR <input type="checkbox"/> Domestic Partner							
<input type="checkbox"/> Add' <input type="checkbox"/> Medical <input type="checkbox"/> Cancel <input type="checkbox"/> Dental			<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /		
C H I L D R E N	<input type="checkbox"/> Add' <input type="checkbox"/> Medical <input type="checkbox"/> Cancel <input type="checkbox"/> Dental		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add' <input type="checkbox"/> Medical <input type="checkbox"/> Cancel <input type="checkbox"/> Dental		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add' <input type="checkbox"/> Medical <input type="checkbox"/> Cancel <input type="checkbox"/> Dental		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Add' <input type="checkbox"/> Medical <input type="checkbox"/> Cancel <input type="checkbox"/> Dental		<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*	<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: If Last Name of spouse/child(ren) is different from Employee's Last Name, please give brief explanation:

*Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

As I am adding my dependent(s), and by signing this document I declare under the penalty of perjury under the laws of the state of California that the following statements are true and correct regarding the above enrolling dependents, as applicable:

My spouse and I are legally married as recognized by the state of California.

My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to my or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.

My grandchildren are: unmarried or not involved in a domestic partnership, and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

I understand that I may be asked for legal proof of the above at any time.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this statement may have cause to bring civil action against me to recover their losses.

Family Coverage Eligibility Requirements

Who can be covered?	Effective dates	Requirements that <u>MUST</u> be met:
New Spouse	Coverage begins on the first of month <u>following</u> date of marriage	<ul style="list-style-type: none"> ■ Spouse must be legally married to eligible Employee and the eligible Employee must agree to notify CHOICE Administrators immediately upon termination of the marriage.
New Baby, Dependent Child, Grandchild†	Coverage will begin from the moment of birth through the end of the calendar month of birth, or the mother's hospitalization if she is a member, whichever is later. Premiums for continuation of coverage for the dependent will be charged beginning on the first of the month <u>following</u> the birth.	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> ■ Born to, a step-child or legal ward of, grandchild† of, or adopted by the eligible Employee or the spouse of the eligible Employee or the Domestic Partner of the eligible Employee ■ Dependent on the Employee for at least 50% of his/her economic support ■ Unmarried ■ <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24</u> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Adopted Child, Stepchild, Non-Temporary Legal Ward	Coverage is effective on the date the member gains the right to control the dependent's healthcare, and premiums will be charged the first of the month <u>following</u> this date.	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> ■ Adopted by, stepchild of, or non-temporary legal ward of the Employee ■ Dependent on the Employee for at least 50% of his/her economic support ■ Unmarried ■ <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24</u> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
Domestic Partner	<p><u>During Initial Enrollment or Group's Annual Open Enrollment:</u> Coverage begins on group's effective date</p> <p><u>Involuntary Loss of Other Coverage:</u> Domestic Partner can be added outside of Open Enrollment only if he/she loses other coverage involuntarily. Coverage is effective the first of following month</p> <p><u>Mid-Year Addition:</u> Mid-year additions of a Domestic Partner will require a State stamped copy of the Certificate of Registered Domestic Partnership within 30 days of issue or a qualifying event (such as involuntary loss of coverage) and a signed affidavit</p>	<p><u>The Employee and Domestic Partner must:</u></p> <ul style="list-style-type: none"> ■ Share a common residence ■ Not be married under either a statutory or common law or part of a domestic partnership ■ Be 18 years of age or older ■ Share an intimate and committed relationship of mutual caring ■ Both be mentally competent ■ Not be related by blood to a degree of closeness that would prohibit marriage in this state ■ Agree to notify CHOICE Administrators immediately upon termination of the domestic partnership <p>Employee and Domestic Partner must also submit a signed affidavit attesting that the above conditions have been met.</p> <p style="text-align: center;">Employee/Domestic Partner must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>
New Baby, Dependent Child, Grandchild†, Adopted Child, Non-Temporary Legal Ward of Domestic Partner	See Domestic Partner above	<p><u>Child must be:</u></p> <ul style="list-style-type: none"> ■ Born to, dependent child of, step-child of, grandchild† of, adopted by, or non-temporary legal ward of the Domestic Partner ■ Dependent on the Employee for at least 50% of his/her economic support ■ Unmarried ■ <u>Under age 19 (unless disabled, disability occurring prior to age 24) or a full time student and under age 24</u> <p><u>Verification of eligibility will occur annually at the child's birthday</u></p> <p><u>Disabled Dependents:</u> Children who are incapable of self-support because of a continuous mental or physical disability that existed before the age limit are eligible for coverage until the incapacity ends. Documentation of proof may be requested. Once the child reaches the age limit for coverage, re-verification of disability will be required annually.</p> <p style="text-align: center;">Dependents must meet <u>all</u> requirements listed in order to be eligible for enrollment</p>

† Grandchild may be covered if the parent is a dependent of the covered employee and the parent is also enrolled.

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):

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

NOTE: This change will be considered to become effective on the day it is received by Kaiser Permanente Choice Solution

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

DATE

Your LEGAL Acknowledgement (Read, Sign & Date Below)

I authorize my physician, healthcare provider, hospital, clinic or other medically related facility to furnish my, and my dependent's, protected health information, including medical records, to the health plan I have chosen through the Kaiser Permanente Choice Solution Program or its authorized agents for the purpose of review, investigation, or evaluation of an application or claim, and for quality assurance and utilization review. I authorize **CHOICE** Administrators and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider any protected health information if such disclosure is necessary to allow the performance of any of those activities. This authorization shall become effective immediately and shall remain in effect for up to 30 months for the date the authorization was signed. I understand that I, or a person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I have read and understand the information provided to me pertaining to the Premium Only Plans and the tax consequences.

I declare under the penalty of perjury under the laws of the state of California that the following statements are true, correct and pertain to the Employer named on this application, myself and my dependents named on this application:

- I am either actively, permanently working for the Employer and considered eligible by my Employer, because I work, either 20+ or 30+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, seasonal, per diem or a 1099 employee or insured by or eligible to be insured by the Employer's union policy.
- My children's dates of birth are accurate. My children are: unmarried or not involved in a domestic partnership, and are financially dependent upon me per the IRS guidelines. My children are born to me or my spouse/domestic partner, or legally adopted and/or a non-temporary legal ward of me or my spouse/domestic partner.
- My grandchildren are: unmarried or not involved in a domestic partnership, and are financially dependent upon my covered child per the IRS guidelines. My grandchildren are born to my or my spouse/domestic partner's covered child, or legally adopted and/or a court-appointed ward of me or my spouse/domestic partner.

I understand that the above statements are subject to audit at any time and **agree** to provide **CHOICE** Administrators with any and all information necessary to prove the above statements.

I understand that false statements and/or failure to provide the information upon request will cause the termination of all Kaiser Permanente Choice Solution benefits 15 days following the date of the notice of termination and I will be held responsible for all services and charges incurred through Kaiser Permanente Choice Solution program providers thereafter.

I understand that any persons, business, or health plan that suffers a loss because of false declarations contained in this statement may have cause to bring civil action against me to recover their losses.

- The representations made are the basis upon which coverage may be issued.
- If any Material fact was omitted or misrepresented, the coverage may be cancelled or the employer's contract rescinded.
- I have READ, UNDERSTAND and ATTEST that myself and my dependents have met all of the eligibility requirements listed on the second page of this application.

Kaiser Foundation Health Plan Arbitration Agreement (applies to KFHP only, does not apply to Kaiser Permanente Insurance Company products):

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if my Group must comply with ERISA, certain benefit-related disputes) any dispute between myself, my heirs or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, 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 my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee SIGN HERE:

Date:



CHOICE ADMINISTRATORS STAFF USE BELOW THIS POINT

PLAN CODE

PROCESSED

EMPLOYEE #

EFFECTIVE DATE