

# Covered California for Small Business Change Request Form for Employers 2017



FOR SMALL  
BUSINESS

Check here if changes are to be effective at renewal.

**Fax completed form to** (949) 809-3264 or  
**mail to Covered California at** P.O. Box 7010, Newport Beach, CA 92658  
**For assistance call** (855) 777-6782

## EMPLOYER INFORMATION

Please list the name and Federal Employer Identification Number you originally applied for Covered California coverage under so that we may locate the correct company record. If the name of your company has changed, list your new company name under "Updated Business Information" below.

Employer name	Federal Employer Identification Number (FEIN)
Employer phone number ( ) -	Covered California for Small Business (CCSB) Case ID #

## REASON FOR CHANGE (CHECK ALL THAT APPLY)

EFFECTIVE DATE  
MM/DD/YYYY

<input type="checkbox"/> CHANGE IN BUSINESS OWNERSHIP	INDICATE DATE CHANGE OF OWNERSHIP EFFECTIVE	
<input type="checkbox"/> CHANGE OF ADDRESS OR OTHER INFORMATION FOR BUSINESS	INDICATE DATE CHANGE OF INFORMATION EFFECTIVE	
<input type="checkbox"/> EMPLOYEES TO BE TERMINATED	INDICATE EFFECTIVE DATE OF TERMINATION	
<input type="checkbox"/> CHANGE OF PLAN LEVEL (METAL TIER)		CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> CHANGE OF PREMIUM CONTRIBUTION AMOUNT		CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> CHANGE OF REFERENCE PLAN		CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> ELECTING EMPLOYEE ONLY COVERAGE		CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> ADDING DEPENDENT COVERAGE		CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> CHANGE OF INFERTILITY OFFER		CHANGE WILL BE EFFECTIVE AT RENEWAL
<input type="checkbox"/> OTHER (PLEASE DESCRIBE)		

## UPDATED BUSINESS INFORMATION (IF APPLICABLE)

1. NEW Business Legal Name		2. NEW Federal Employer Identification Number (FEIN)	
3. NEW Doing Business As (DBA)		4. NEW State Employer Identification Number (SEIN)	
5. Change in total number of full-time equivalent employees on payroll from previous year	6. Change in total number of eligible employees from previous year	OLD	NEW

### CHANGE IN OWNERSHIP You must provide the following documents

<input type="checkbox"/> Sole Proprietor	Local business license or Fictitious Business Name Filing <b>AND</b> DE-9C or Payroll records for 30 days
<input type="checkbox"/> Corporation	Articles of Incorporation (filed and stamped) <b>AND</b> DE-9C or Payroll records for 30 days <b>AND</b> Statement of Information (if officers are offered coverage and not listed on DE-9C) or Corporate Meeting minutes listing all officers names
<input type="checkbox"/> Partnership	Partnership Agreement <b>AND</b> Federal Tax ID Appointment letter <b>AND</b> DE-9C or Payroll records for 30 days
<input type="checkbox"/> Limited Partnership (LI)	Partnership Agreement <b>AND</b> Federal Tax ID Appointment letter <b>AND</b> DE-9C or Payroll records for 30 days
<input type="checkbox"/> Limited Liability Partnership (LLP)	Partnership Agreement or Federal Tax ID Appointment <b>AND</b> DE-9C or Payroll records for 30 days
<input type="checkbox"/> Limited Liability Company (LLC)	Articles of Organization Operating Agreement or Statement of Information <b>AND</b> DE-9C or Payroll records for 30 days

**?** **NEED HELP WITH THIS FORM?** Contact your Covered California Certified Insurance Agent with questions, visit [CoveredCA.com](http://CoveredCA.com) or call us at (855) 777-6782. Para obtener una copia de este formulario en Español, llame (855) 777-6782.

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Employer name

CCSB Case ID#

## PLEASE COMPLETE ONLY THE INFORMATION THAT HAS CHANGED

### Primary Contact (official communications will be addressed to the primary contact)

1. First name, Last name, &amp; Suffix

2. Phone number  
( ) -

3. Email address (OPTIONAL)

4. What is the preferred method of communication?  
 Mail  Email  Phone

5. Preferred spoken or written language (OPTIONAL—if not English)

### Authorized Representative (if you want to name someone as your authorized representative — OPTIONAL)

6. First name, Last name, &amp; Suffix

7. Phone number  
( ) -

8. Email address (OPTIONAL)

### Company Addresses

9. California business address - street address 1 (must be a California street address)

10. Street address 2

11. City

12. State

13. ZIP code

14. County

15. Is your mailing address the same as your California business address?  Yes  No16. Is your billing address the same as your California business address?  Yes  No

17. Mailing address

18. City

19. State

20. ZIP code

21. County

22. Billing address

23. City

24. State

25. ZIP code

26. County

## LIST ANY EMPLOYEES YOU ARE TERMINATING FROM COVERAGE AND INDICATE REASON

**EMPLOYEE INFORMATION CHANGES:** To *change* employee information or coverage such as adding a dependent or changing a home address, please attach a completed Change Request Form for Employees.

EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON <input type="checkbox"/> Voluntary Withdrawal <input type="checkbox"/> Reduction of Hours	<input type="checkbox"/> Too Expensive <input type="checkbox"/> Termination with cause	<input type="checkbox"/> Death <input type="checkbox"/> Separation/Divorce	LAST DAY OF COVERAGE

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## CHANGE PLAN LEVELS OFFERED TO YOUR EMPLOYEES (IF APPLICABLE)

**PLEASE NOTE:** Plan levels may be changed only at renewal.

<b>CURRENT Plan Level</b>	<input type="checkbox"/> Bronze	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum
<b>NEW Plan Level</b>	<input type="checkbox"/> Bronze	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum

**Dual Tier Choice:** You may offer your employees the option to select from adjoining plan levels as indicated below:

<b>Dual Tier Plan Level</b>	<input type="checkbox"/> Bronze + Silver	<input type="checkbox"/> Silver + Gold	<input type="checkbox"/> Gold + Platinum
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## CHANGE YOUR REFERENCE PLAN (IF APPLICABLE)

**PLEASE NOTE:** Reference Plans may be changed only at renewal.

<b>CURRENT Reference Plan</b>	Health Carrier	<input type="text"/>
	Plan Name	<input type="text"/>
	Plan Level	<input type="text"/>
<b>NEW Reference Plan</b>	Health Carrier	<input type="text"/>
	Plan Name	<input type="text"/>
	Plan Level	<input type="text"/>

## CHANGE YOUR PREMIUM CONTRIBUTION (IF APPLICABLE)

**PLEASE NOTE:** Premium contributions may be changed only at renewal.

<b>CURRENT Contribution Level</b>	Employee premium	_____ % (50% minimum)	
	Dependent premium	_____ % (optional, enter "0" if no contribution)	
<b>NEW Contribution Level</b>	Employee premium	_____ % (50% minimum)	
	Dependent premium	_____ % (optional, enter "0" if no contribution)	

## INFERTILITY

Do you want to offer plans that include infertility coverage?  Yes  No

**Infertility offering rules for Employers with 20 or more FTE employees:**

- Employers with 20 or more full-time equivalent (FTE) employees who choose to offer Infertility benefits to their employees, all products shall include Infertility benefits.
- Employers with 20 or more FTE employees who choose to not offer Infertility benefits to their employees, all products shall not include Infertility benefits.

**Infertility offering rules for Employers with less than 20 FTE employees:**

If Employer chooses to offer Infertility benefits, the following applies:

- Employees selecting an HMO product cannot select a plan with infertility benefits.
- Employees selecting either a PPO or EPO product must select a plan with Infertility benefits.

If Employer chooses to not offer Infertility benefits, the following applies:

- Employees electing an HMO product cannot select a plan with Infertility benefits.
- Employees electing either a PPO or EPO product cannot select a plan with Infertility benefits.

## CERTIFIED INSURANCE AGENT INFORMATION

Please tell us the Certified Insurance Agent who assisted you with your Covered California for Small Business health coverage.

Certified Insurance Agent Name	Email	Phone Number
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I did not receive assistance from a Certified Insurance Agent.

## SIGN THE FORM AND SEND TO COVERED CALIFORNIA

Signature of Business Owner/Authorized Company Officer	Title
Print Name	Date

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