

Covered California for Small Business Change Request Form for Employers



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 (877) 453-9198

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"/> 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 employees on payroll from previous year OLD NEW	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 AND DE-9C or Payroll records for 30 days
<input type="checkbox"/> Corporation	Articles of Incorporation (filed and stamped) AND DE-9C or Payroll records for 30 days AND 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 AND Federal Tax ID Appointment letter AND DE-9C or Payroll records for 30 days
<input type="checkbox"/> Limited Partnership (LI)	Partnership Agreement AND Federal Tax ID Appointment letter AND DE-9C or Payroll records for 30 days
<input type="checkbox"/> Limited Liability Partnership (LLP)	Partnership Agreement or Federal Tax ID Appointment AND DE-9C or Payroll records for 30 days
<input type="checkbox"/> Limited Liability Company (LLC)	Articles of Organization Operating Agreement or Statement of Information AND 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** or call us at (877) 453-9198. Para obtener una copia de este formulario en Español, llame (877) 453-9198.

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Employer name	CCSB Case ID#
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PLEASE COMPLETE ONLY THE INFORMATION THAT HAS CHANGED
Primary Contact (official communications will be addressed to the primary contact)

1. First name, Last name, & Suffix	
2. Phone number () –	3. Email address (OPTIONAL)
4. What is the preferred method of communication? <input type="checkbox"/> Mail <input type="checkbox"/> Email <input type="checkbox"/> 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, & 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. Is your billing address the same as your California business address? <input type="checkbox"/> Yes <input type="checkbox"/> 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			LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON			LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON			LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON			LAST DAY OF COVERAGE
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON			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.

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

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

Dual Tier Plan Level	<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.

CURRENT Reference Plan	Health Carrier	<input style="width: 95%;" type="text"/>
	Plan Name	<input style="width: 95%;" type="text"/>
	Plan Level	<input style="width: 95%;" type="text"/>

NEW Reference Plan	Health Carrier	<input style="width: 95%;" type="text"/>
	Plan Name	<input style="width: 95%;" type="text"/>
	Plan Level	<input style="width: 95%;" type="text"/>

CHANGE YOUR PREMIUM CONTRIBUTION (IF APPLICABLE)

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

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

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

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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