Covered California for Small Business
CHANGE REQUEST FORM FOR EMPLOYERS

COVERED CALIFORNIA SMALL BUSINESS

☐ Check here if changes are to be effective at renewal.
Must be received prior to renewal date.

Fax completed form to (949) 809-3264
Mail to Covered California at P.O. Box 7010, Newport Beach, CA 92658
For assistance call (855) 777-6782
or email ccsbeligibility@covered.ca.gov

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)	SIC code

Employer phone number	Covered California for Small Business (CCSB) Group #

REASON FOR CHANGE (CHECK ALL THAT APPLY)

			EFFECTIVE DATE MM/DD/YYYY
☐	CHANGE IN BUSINESS OWNERSHIP	INDICATE DATE CHANGE OF OWNERSHIP EFFECTIVE	
☐	CHANGE OF ADDRESS OR OTHER INFORMATION FOR BUSINESS	INDICATE DATE CHANGE OF INFORMATION EFFECTIVE	
☐	EMPLOYEES TO BE TERMINATED	INDICATE EFFECTIVE DATE OF TERMINATION	
☐	CHANGE OF PLAN LEVEL (METAL TIER)		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐	CHANGE OF PREMIUM CONTRIBUTION AMOUNT		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐	CHANGE OF REFERENCE PLAN		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐	ELECTING EMPLOYEE ONLY COVERAGE		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐	ADDING DEPENDENT COVERAGE		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐	CHANGE OF INFERTILITY OFFER		CHANGE WILL BE EFFECTIVE AT RENEWAL
☐	LESS THAN FTE	☐ Employee only ☐ Employee + family	
☐	50 - 100 FTE	☐ Employee only ☐ Employee + family	
☐	CHANGING COBRA STATUS	☐ Cal COBRA (19 or less FTE) to Fed COBRA (20 or more FTE) ☐ Fed COBRA (20 or more FTE) to Cal COBRA (19 or less FTE)	
☐	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)

CHANGE IN OWNERSHIP You must provide the following documents

☐	Sole Proprietor	Local business license or Fictitious Business Name Filing **AND** DE-9C or Payroll Records for 30 Days or Prior Carrier Bill (For Employers with 3+ Enrolling Employees)
☐	Corporation	Articles of Incorporation (filed and stamped) **AND** DE-9C or Payroll Records for 30 Days or Prior Carrier Bill (For Employers with 3+ Enrolling Employees) **AND** Statement of Information (if officers are offered coverage and not listed on DE-9C) or Corporate Meeting minutes listing all officers names
☐	Partnership	Partnership Agreement **AND** Federal Tax ID Appointment letter **AND** DE-9C or Payroll Records for 30 Days or Prior Carrier Bill (For Employers with 3+ Enrolling Employees)
☐	Limited Partnership (LI)	Partnership Agreement **AND** Federal Tax ID Appointment letter **AND** DE-9C or Payroll Records for 30 Days or Prior Carrier Bill (For Employers with 3+ Enrolling Employees)
☐	Limited Liability Partnership (LLP)	Partnership Agreement or Federal Tax ID Appointment **AND** DE-9C or Payroll Records for 30 Days or Prior Carrier Bill (For Employers with 3+ Enrolling Employees)
☐	Limited Liability Company (LLC)	Articles of Organization Operating Agreement or Statement of Information **AND** DE-9C or Payroll Records for 30 Days or Prior Carrier Bill (For Employers with 3+ Enrolling Employees)

NEED HELP WITH THIS FORM? Contact your Covered California Insurance Agent with questions, visit **coveredca.com/forsmallbusiness** 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 Group #

PLEASE COMPLETE ONLY THE INFORMATION THAT HAS CHANGED

Primary Contact (official communications will be addressed to the primary contact) ☐ **Check here if there are NO Changes**

1. First name, Last name, & Suffix	
2. Phone number	3. Email address
4. Do you want to go paperless? ☐ Yes ☐ No	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

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 ☐ No			16. 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

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 ☐ Waive Coverage ☐ Too Expensive ☐ Death ☐ Resigned ☐ Reduction of Hours ☐ Termination with cause ☐ Separation/Divorce		LAST DAY OF COVERAGE	
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON ☐ Waive Coverage ☐ Too Expensive ☐ Death ☐ Resigned ☐ Reduction of Hours ☐ Termination with cause ☐ Separation/Divorce		LAST DAY OF COVERAGE	
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON ☐ Waive Coverage ☐ Too Expensive ☐ Death ☐ Resigned ☐ Reduction of Hours ☐ Termination with cause ☐ Separation/Divorce		LAST DAY OF COVERAGE	
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON ☐ Waive Coverage ☐ Too Expensive ☐ Death ☐ Resigned ☐ Reduction of Hours ☐ Termination with cause ☐ Separation/Divorce		LAST DAY OF COVERAGE	
EMPLOYEE LAST NAME	FIRST NAME	MI	SSN / TAX ID #
REASON ☐ Waive Coverage ☐ Too Expensive ☐ Death ☐ Resigned ☐ Reduction of Hours ☐ Termination with cause ☐ Separation/Divorce		LAST DAY OF COVERAGE	

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Employer name	CCSB Group #

CHANGE PLAN LEVELS OFFERED TO YOUR EMPLOYEES (IF APPLICABLE)

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

1 Metal Tier: You may offer your employees the option to select from touching plan levels as indicated below:

1 Metal Tier Plan Level	☐	Bronze	☐	Silver	☐	Gold	☐	Platinum

2 Metal Tiers: You may offer your employees the option to select from touching plan levels as indicated below:

2 Metal Tier Plan Level	☐	Bronze + Silver	☐	Silver + Gold	☐	Gold + Platinum

3 Metal Tiers: You may offer your employees the option to select from touching plan levels as indicated below:

3 Metal Tier Plan Level	☐	Bronze + Silver + Gold	☐	Silver + Gold + Platinum

4 Metal Tiers: You may offer your employees the option to select from touching plan levels as indicated below:

4 Metal Tier Plan Level	☐	Bronze + Silver + Gold + Platinum

CHANGE YOUR REFERENCE PLAN (IF APPLICABLE)

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

NEW Reference Plan

Health Insurance Company _____

Plan Name _____

Plan Level _____

CHANGE YOUR MONTHLY PREMIUM CONTRIBUTION (IF APPLICABLE)

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

NEW Contribution Level

Employee monthly premium _____ % (50% minimum)

Dependent monthly premium _____ % (optional, enter "0" if no contribution)

INFERTILITY

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

All employers have the option to offer infertility coverage as part of their health insurance. If an employer chooses to offer infertility benefits to their employees, all health insurance plans available will include infertility benefits. If an employer chooses not to offer infertility coverage to their employees, the health insurance plans available to their employees will not include infertility benefits.

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Employer name	CCSB Group #

DENTAL COVERAGE

Do you want to offer dental coverage? ☐ Yes ☐ No

CHANGE YOUR DENTAL REFERENCE PLAN (IF APPLICABLE)

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

NEW Reference Plan

Dental Insurance Company _____

Plan Name _____

Plan Level _____

CHANGE YOUR DENTAL MONTHLY PREMIUM CONTRIBUTION (IF APPLICABLE)

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

NEW Contribution Level

Employee monthly premium _____ % (optional, enter "0" if no contribution)

Dependent monthly premium _____ % (optional, enter "0" if no contribution)

INSURANCE AGENT INFORMATION

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

Insurance Agent Name	Email	Phone Number

☐ I did not receive assistance from an Insurance Agent.

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ATTESTATION, ARBITRATION – read, complete & sign.

To participate in Covered California for Small Business, you must attest to the following:

A.) I understand that the information I provided on this form will only be used to determine eligibility for and to facilitate enrollment in health coverage and will be kept private as required by federal and state law.

B.) My waiting period is in compliance with 42 U.S.C. § 300gg-7, Section 10198.7(c) of the California Insurance Code, as amended by Statutes 2013-2014, 1st Ex. Sess., ch. 1, § 7 and Section 1357.51(c) of the California Health and Safety Code, as amended by Statutes 2013-2014, 1st Ex. Sess., ch. 2, § 2, and all of my qualified employees have complied with the waiting period;

C.) If my employee roster is included, I have consent from everyone I have listed on this application to include their personally identifiable information, including but not limited to dates of birth, Social Security or tax identification numbers, addresses, and phone numbers.

D.) I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, disability, religion, marital status or veteran status.

E.) I know that SHOP will not consider my group coverage approved until the initial invoice has been paid in full and delivered to the SHOP or postmarked by the due date indicated on the invoice.

F.) I know that I must continue to make the required payments of the total balance due by the due date on the invoice, to continue to be an eligible employer in SHOP.

G.) I know that I must inform all eligible employees of the availability of coverage and that those not electing coverage must wait one year or experience a qualifying event to obtain coverage through my group plan if they later decide they would like to have coverage.

H.) I understand that once coverage is approved by CCSB, changes to the coverage cannot be implemented after my effective date until my next annual election of coverage period, except to the extent the qualified employer exercises the right to change coverage with the same issuer within the first 30 days of the date coverage begins pursuant to Health and Safety Code 1357.504 (c) and the Insurance Code Section 10753.06.5 (c).

I.) I understand that health insurance coverage through the CCSB is subject to the applicable terms and conditions of the health insurance company contract or policy and applicable state law, which will determine the procedures, exclusions and limitations relating to the coverage and will govern in the event of any conflict with CCSB or health insurance company benefits comparison, summary or other description of coverage.

J.) I understand that once membership information is transmitted to the selected health insurance company, the date coverage begins for the group cannot be changed nor can the coverage be ended until after the first month of coverage.

K.) I understand that the attestations in this section are subject to audit by CCSB at any time.

L.) I understand that the attestations in this section must be maintained in order for my group to continue coverage through CCSB.

Binding Arbitration Agreement:

I understand that, if I select a Health Plan that uses mandatory binding arbitration to resolve disputes, I am agreeing to arbitrate claims that relate to my or a dependent's membership in the Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law). I understand that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and the Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including, for premises liability, relating to the coverage for, or delivery of, services or items, or, if I select a Kaiser Permanente Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), 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 our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is in the Health Plan's coverage document, which is available for my review.

☐ **I have read and attest to the foregoing requirements A-L (above) for participation in CCSB.**

☐ **I have read and agree to the Binding Arbitration agreement.**

SIGN THE FORM AND SEND TO COVERED CALIFORNIA

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

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