

Small Group Medical Plan Change Request Form

Effective Date: _____
(To be completed by Underwriting)

(For existing enrollments only)

Instructions

Prior to requesting a different plan, please reference the Product Catalog that describes the plan you are considering. This guide details the benefits, copayments, and annual deductibles of the plans. The plan you choose must be a part of your employer's Small Group benefit package.

1. You, the employee, must complete this medical plan change request form. You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full and all signatures/dates must be completed; otherwise, this form may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. Type or print clearly in blue or black ink.

Group Name/Group Number: _____

Please indicate your current coverage/plan name: _____

1. Medical Coverage Selection – Check only one Medical Plan:

A. Choice of Coverage – Please change my coverage to:

Choice Simplified			Multi-Choice State		
Select Plus	15/20%	<input type="checkbox"/> AK-RV	Core	15/10%	<input type="checkbox"/> AK-R2
Select Plus	2000/30%	<input type="checkbox"/> AK-RW	Core	30/20%	<input type="checkbox"/> AK-R3
Select Plus HSA	6500/0%	<input type="checkbox"/> AK-RX	Core	45/2000/20%	<input type="checkbox"/> AK-R4
Core	15/20%	<input type="checkbox"/> AK-RY	Core	75/6300/100%	<input type="checkbox"/> AK-R5
Core	2000/30%	<input type="checkbox"/> AK-RZ	Core HSA	4500/40%	<input type="checkbox"/> AK-R6
Core HSA	6500/0%	<input type="checkbox"/> AK-R1	Navigate	15/10%	<input type="checkbox"/> AK-SI
Navigate	15/20%	<input type="checkbox"/> AK-SF	Navigate	30/20%	<input type="checkbox"/> AK-SJ
Navigate	2000/30%	<input type="checkbox"/> AK-SG	Navigate	45/2000/20%	<input type="checkbox"/> AK-SK
Navigate HSA	6500/0%	<input type="checkbox"/> AK-SH	Navigate	75/6300/100%	<input type="checkbox"/> AK-SL
Select Plus Direct	20/250/20%	<input type="checkbox"/> AK-R7	Navigate HSA	4500/40%	<input type="checkbox"/> AK-SM
Select Plus Direct	20/750/20%	<input type="checkbox"/> AK-R8	Signature	15-40/10%	<input type="checkbox"/> AK-RK
Select Plus Direct	20/1000/20%	<input type="checkbox"/> AK-R9	Signature	30-55/20%	<input type="checkbox"/> AK-RL
Select Plus Direct	30/2000/30%	<input type="checkbox"/> AK-SA	Signature	45-75/20%/2000ded	<input type="checkbox"/> AK-RM
Core Direct	20/250/20%	<input type="checkbox"/> AK-SB	Focus	15-40/10%	<input type="checkbox"/> AK-RN
Core Direct	20/750/20%	<input type="checkbox"/> AK-SC	Focus	30-55/20%	<input type="checkbox"/> AK-RO
Core Direct	20/1000/20%	<input type="checkbox"/> AK-SD	Focus	45-75/20%/2000ded	<input type="checkbox"/> AK-RP
Core Direct	30/2000/30%	<input type="checkbox"/> AK-SE	Alliance	15-40/10%	<input type="checkbox"/> AK-RQ
Navigate Direct	20/250/20%	<input type="checkbox"/> AK-SN	Alliance	30-55/20%	<input type="checkbox"/> AK-RR
Navigate Direct	20/750/20%	<input type="checkbox"/> AK-SO	Alliance	45-75/20%/2000ded	<input type="checkbox"/> AK-RS
Navigate Direct	20/1000/20%	<input type="checkbox"/> AK-SP	Alliance HSA	40%/4500ded	<input type="checkbox"/> AK-ST
Navigate Direct	30/2000/30%	<input type="checkbox"/> AK-SQ	Non-Differential PPO	2000/30%	<input type="checkbox"/> AK-RU
Signature	20-40/30%	<input type="checkbox"/> AK-QY			
Signature	30-50/30%	<input type="checkbox"/> AK-QZ			
Signature	30-50/30%/1000ded	<input type="checkbox"/> AK-Q1			
Signature	45-65/40%/2000ded	<input type="checkbox"/> AK-Q2			
Advantage	20-40/30%	<input type="checkbox"/> AK-Q4			
Advantage	30-50/30%	<input type="checkbox"/> AK-Q5			
Advantage	30-50/30%/1000ded	<input type="checkbox"/> AK-Q6			
Advantage	45-65/40%/2000ded	<input type="checkbox"/> AK-Q7			
Focus	20-40/30%	<input type="checkbox"/> AK-Q9			
Focus	30-50/30%	<input type="checkbox"/> AK-RA			
Focus	30-50/30%/1000ded	<input type="checkbox"/> AK-RB			
Focus	45-65/40%/2000ded	<input type="checkbox"/> AK-RC			
Alliance	20-40/30%	<input type="checkbox"/> AK-RE			
Alliance	30-50/30%	<input type="checkbox"/> AK-RF			
Alliance	30-50/30%/1000ded	<input type="checkbox"/> AK-RG			
Alliance	45-65/40%/2000ded	<input type="checkbox"/> AK-RH			
Alliance	30%/2000ded	<input type="checkbox"/> AK-RI			
Alliance HSA	0%/6500ded	<input type="checkbox"/> AK-RJ			
Non-Differential PPO	2000/30%	<input type="checkbox"/> AK-RU			

Group Name/Group Number: _____

2. Subscriber Information

B. Complete address portion ONLY if a recent change

Last Name		First Name		M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Social Security or I.D. Number	
Street Address (P.O. Box not acceptable)					# of Dependents including Spouse		Spouse's Social Security or I.D. No.
City		State	ZIP Code		Home Phone No. ()		Business Phone No. ()
Occupation			Employer Name			No. of Hours Worked Per Week	

3. Subscriber/Family Information

C. List yourself and all eligible family members requesting a change in coverage. If you select a UnitedHealthcare HMO, you must choose a Primary Care Physician for each member of your family. All family members must be in the same plan.

1	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Self	Last Name		Social Security Number		Primary Care Physician Name		PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
			First Name	M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name					
2	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Spouse	Last Name		Social Security Number		Primary Care Physician Name		PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
			First Name	M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name					
3	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Relationship	Last Name		Social Security Number		Primary Care Physician Name		PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
			First Name	M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name					
4	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Relationship	Last Name		Social Security Number		Primary Care Physician Name		PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
			First Name	M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name					
5	<input type="checkbox"/> Add <input type="checkbox"/> Delete	Relationship	Last Name		Social Security Number		Primary Care Physician Name		PCP #	Primary Care Physician (PCP) Number	Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
			First Name	M.I.	Date of Birth (Month - Day - Year) - -	Medical Group Name					

4. Signature Required for Terms and Conditions – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all pages of this form. A reproduction of this authorization shall be as valid as the original.

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.

Signature (Required) X	Date (Required)
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Group Name/Group Number: _____

5. Signature Required for Binding Arbitration - Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. A reproduction of this authorization shall be as valid as the original.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNITEDHEALTHCARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature (Required)

X

Date (Required)