

CHANGE REQUEST FORM

GENERAL INSTRUCTIONS:

Employees use **this form** to update personal information or to add/delete dependent coverage.
 Employers use the **Employee Termination of Insurance Form** to notify us of coverage termination for an employee due to a Qualifying Event.
 Active Employees use the **Coverage Declination Form** to voluntarily cancel one or more types of coverage (health, dental, vision, life).

This Form must be received by the Administrator no later than 30 days after the qualifying event takes place in order to qualify for coverage. Late submissions will be subject to medical underwriting by the insurance carrier.

- * Cancellations of coverage will take effect on the last day of the month after receipt of your request by the plan administrator.
- * Additions to coverage will become effective on the first day of the month following event (marriage, birth, loss of coverage, other).
- * Please attach a copy of marriage certificate or legal documents as applicable.

SECTION 1: PERSONAL INFORMATION

Company Name		Company Phone # () -	Builders Exchange/Association
Type of Change Requested: <input type="checkbox"/> Name <input type="checkbox"/> Qualifying Event (attach proof of the event) <input type="checkbox"/> Address <input type="checkbox"/> Add/Delete Dependents		Type of Qualifying Event (proof is required)*: <input type="checkbox"/> Marriage* <input type="checkbox"/> Loss of Coverage* <input type="checkbox"/> Divorce <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Other: _____	
Date of Event (i.e., date of birth, date moved, married, divorced, last day of coverage, etc.)		Requested Effective Date (1st of the Month following the Event)	
Employee Last Name	Employee First Name	Employee Middle Initial	
Date of Birth / /	Social Security Number - -		
Physical Address	City	State	Zip Code

SECTION 2: NAME/ADDRESS CHANGE Is the address above new? Yes No
 (Please complete this section only if reporting a Name/Address change, attach proof of name change)

New Last Name	First Name	Middle Initial	Home Telephone
New Mailing Address (if different from physical)	City	State	Zip Code

SECTION 3: COVERAGE CHANGE

(complete only if you are an **Active** Employee who wants to Add or Cancel Coverage for any Dependents)

Coverage Type	Last Name	First Name	Gender	Social Security Number	Date of Birth	Full Time Student	Disabled Dependent	Health Net Only: Primary Care Physician Name	Kaiser Only: Use Medical Record Number ID#
<input type="checkbox"/> Spouse; or <input type="checkbox"/> DP <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu			<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	/ /				
Dependent #1 <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu			<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent #2 <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu			<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent #3 <input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Chiro/Acu			<input type="checkbox"/> Male <input type="checkbox"/> Female	- -	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		

For full-time student or disabled dependent changes/additions, please submit an Over Age Dependent or Disabled Dependent Certification in addition to this form.

If **Last Name** of spouse/domestic partner or dependent is different from Employee's Last Name, please explain:

If **Address** of spouse/domestic partner or dependent is different from Employee's Address, please list here:

INTERNAL USE ONLY	Tier (I to V)	Plan	Group #:
<input type="checkbox"/> HealthNet <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> Kaiser <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> F	<input type="checkbox"/> Tier <input type="checkbox"/> Tier		
<input type="checkbox"/> MetLife <input type="checkbox"/> ML Voluntary	<input type="checkbox"/> 1-5 (I) <input type="checkbox"/> 6-19 (II) <input type="checkbox"/> 20+ (III)	<input type="checkbox"/> MLP <input type="checkbox"/> MLP+O <input type="checkbox"/> MLS <input type="checkbox"/> Sav+	
<input type="checkbox"/> ASH <input type="checkbox"/> BV or <input type="checkbox"/> VSP <input type="checkbox"/> BV Voluntary	<input type="checkbox"/> 2-9(I) <input type="checkbox"/> 10+ (II) <input type="checkbox"/> E <input type="checkbox"/> S <input type="checkbox"/> DP <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> E <input type="checkbox"/> E+1 <input type="checkbox"/> E+2* <input type="checkbox"/> E <input type="checkbox"/> E+1 <input type="checkbox"/> E+2*	<input type="checkbox"/> Chiro Only <input type="checkbox"/> Chiro+Acu Waiting Period:	BX/Assoc:

CHANGE REQUEST FORM

SIGNATURE PAGE

SECTION 4: YOUR LEGAL ACKNOWLEDGEMENT (Please 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 NBBE 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 NBBE administrator and the health plan I have chosen, and their agents, designees or representatives, to disclose to a hospital, health plan, insurer, or healthcare provider and 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 from 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 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, myself and my dependents named on this application:

- I am either actively working for the Employer and considered eligible by my Employer, because I work, 20+ hours per week, or I am an eligible COBRA/Cal-COBRA participant.
- I am not a temporary, per diem, or a 1099 employee insured by or eligible to be insured by the Employer's union policy.
- My spouse and I are legally married or my domestic partner and I are registered with the Secretary of State of California as defined by State Family Code 297.
- My children's dates of birth are accurate. My children are: unmarried and financially dependent upon me per IRS guidelines. My children are born to me or my spouse or legally adopted by me and/or my spouse/registered 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 benefits and I will be held responsible for all services and charges incurred through the Builders Exchanges/Association 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.

I understand that the above statements are subject to audit at any time and **agree** to provide the NBBE administrator 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 benefits and I will be held responsible for all services and charges incurred through the NBBE 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.

EMPLOYEE SIGN HERE:

DATE:

X

Use for effective dates 4/1/2010 - 3/31/2010