CALIFORNIA

Small Group Medical Plan Change Request Form

(For existing enrollments only)

UnitedHealthcare®

Effective Date: _____
(To be completed by Underwriting)

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:

UnitedHealthcare Select Plus
- ☐ 15/10% Plan GN-3
- ☐ 15/250/10% Plan GO-V
- ☐ 15/500/10% Plan GO-W
- ☐ 15/1000/10% Plan GO-X
- ☐ 25/1800/20% Plan GO-Y
- ☐ 4500/20% Plan GP-5
- ☐ 15/750/20% Plan 7V-L
- ☐ 35/1800/30% Plan 7V-M

UnitedHealthcare Select Plus HSA
- ☐ 1500/20% Plan GN-4
- ☐ 2000/20% Plan GN-5
- ☐ 3500/20% Plan GN-6
- ☐ 5000/20% Plan GN-7

UnitedHealthcare Signature
- ☐ 20-40/250d Plan 6X-9
- ☐ 30-50/1000d Plan 6Y-A
- ☐ 30-50/900d/1000d Plan 6Y-B
- ☐ 30-50/25%/1750ded Plan 3T-N
- ☐ 50-75/30%/4500ded Plan 3T-P

UnitedHealthcare Advantage
- ☐ 20-40/250d Plan 6Y-C
- ☐ 30-50/1000d Plan 6Y-D
- ☐ 30-50/900d/1000d Plan 6Y-E
- ☐ 30-50/25%/1750ded Plan 3T-T
- ☐ 50-75/30%/4500ded Plan 3T-V

UnitedHealthcare Alliance
- ☐ 20-40/250d Plan 6Y-F
- ☐ 30-50/1000d Plan 6Y-G
- ☐ 30-50/900d/1000d Plan 6Y-H
- ☐ 30-50/25%/1750ded Plan 3T-Z
- ☐ 50-75/30%/4500ded Plan 3T-2

UnitedHealthcare Alliance HSA
- ☐ 20%/2000ded Plan 3T-4
- ☐ 20%/3500ded Plan 3T-5

UnitedHealthcare Select Plus
- ☐ 15/10% Plan GN-3
- ☐ 15/250/10% Plan GO-V
- ☐ 15/500/10% Plan GO-W
- ☐ 15/1000/10% Plan GO-X
- ☐ 25/1800/20% Plan GO-Y
- ☐ 4500/20% Plan GP-5
- ☐ 35/1800/30% Plan 7V-M

UnitedHealthcare Select Plus HSA
- ☐ 2000/20% Plan GN-5
- ☐ 3500/20% Plan GN-6

UnitedHealthcare Core
- ☐ 15/10% Plan AB-4Y
- ☐ 15/250/10% Plan AB-44
- ☐ 15/500/10% Plan AB-45
- ☐ 15/1000/10% Plan AB-46
- ☐ 25/1800/20% Plan AB-47
- ☐ 35/1800/30% Plan AB-5A
- ☐ 4500/20% Plan AB-48

UnitedHealthcare Core HSA
- ☐ 2000/20% Plan AB-41
- ☐ 3500/20% Plan AB-42

UnitedHealthcare Signature
- ☐ 20-40/250d Plan 6X-9
- ☐ 30-50/1000d Plan 6Y-A
- ☐ 30-50/900d/1000d Plan 6Y-B
- ☐ 30-50/25%/1750ded Plan 3T-N
- ☐ 50-75/30%/4500ded Plan 3T-P

UnitedHealthcare Advantage
- ☐ 20-40/250d Plan 6Y-C
- ☐ 30-50/1000d Plan 6Y-D
- ☐ 30-50/900d/1000d Plan 6Y-E
- ☐ 30-50/25%/1750ded Plan 3T-T
- ☐ 50-75/30%/4500ded Plan 3T-V

UnitedHealthcare Alliance
- ☐ 20-40/250d Plan 6Y-F
- ☐ 30-50/1000d Plan 6Y-G
- ☐ 30-50/900d/1000d Plan 6Y-H
- ☐ 30-50/25%/1750ded Plan 3T-Z
- ☐ 50-75/30%/4500ded Plan 3T-2

UnitedHealthcare Alliance HSA
- ☐ 20%/2000ded Plan 3T-4
- ☐ 20%/3500ded Plan 3T-5

UnitedHealthcare Focus
- ☐ 20-40/250d Plan AB-YI
- ☐ 30-50/1000d Plan AB-YJ
- ☐ 30-50/900d/1000d Plan AB-YK
- ☐ 30-50/25%/1750d Plan AB-YL
- ☐ 50-70/30%/4500d Plan AB-YM

UnitedHealthcare Select
- ☐ 20/10% Plan 77-C
- ☐ 30/20% Plan 77-D
- ☐ 45/1500/20% Plan 77-E
- ☐ 4500/40% Plan 77-F

UnitedHealthcare Alliance
- ☐ 20-40/250d Plan AB-GV
- ☐ 30-50/600d Plan AB-GW

UnitedHealthcare Alliance HSA
- ☐ 20%/1500ded Plan AB-GX
- ☐ 40%/4500ded Plan 77-B

Non-Differential PPO
- ☐ 2000/20% Plan GN-2

Group Name/Group Number: _____

2. Subscriber Information

B. Complete address portion ONLY if a recent change

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ 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	☐ Add ☐ Delete	Self	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
2	☐ Add ☐ Delete	Spouse	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
3	☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
4	☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	First Name M.I.	Date of Birth (Month - Day - Year) – –	Medical Group Name			
5	☐ Add ☐ Delete	Relationship	Last Name	Social Security Number	Primary Care Physician Name	PCP #	Primary Care Physician (PCP) Number	Existing Patient? ☐ Yes ☐ No
		☐ Female ☐ Male	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)	Date (Required)
X	

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)	Date (Required)
X	