

Small Group Renewal Medical Plan Change Request

Instructions:

- Please sign, print and return your completed form to small.group@anthem.com, by fax at 855-750-2227, or return through **ESubmit**.
- Self-Service options for submitting request are available through **EmployerAccess**.
- The plan selection must be noted in section 2.

Please note: Plan changes may result in rate and benefit changes.

New enrollees or family additions must complete an employee application requesting coverage.

Section 1: Please tell us who you are and how we can reach you.

Group/Case no.	Company name	Contact name	Employer tax ID no. (required)
Form 5500 ID no. (if applicable)	Phone no.	Fax no.	Email address (required)

Section 2: Please provide network, current plan(s) and requested plan(s) upon your anniversary date for each current active plan(s) offered.

Please choose one PPO and/or one HMO network.	
PPO plans: <input type="checkbox"/> Prudent Buyer PPO Network <input type="checkbox"/> Select PPO Network Prudent Buyer PPO and Select PPO network plans can only be offered alongside other plans with the same network type. For example, plans on the Select PPO network can be offered alongside other plans on the Select PPO network, but they cannot be offered alongside plans on the Prudent Buyer PPO network. (Not all network options are available in every area.)	
HMO plans: <input type="checkbox"/> CaliforniaCare HMO Network <input type="checkbox"/> Select HMO Network <input type="checkbox"/> Priority Select HMO Network <input type="checkbox"/> Vivity CaliforniaCare HMO, Select HMO, Priority Select HMO, and Vivity network plans can only be offered alongside other plans with the same network type. For example, plans on the Select HMO network can be offered alongside other plans on the Select HMO network, but they cannot be offered alongside plans on the CaliforniaCare HMO network. (Not all network options are available in every area.) Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment, the network or physician/medical group is not available, or an employee does not reside or work in the geographical service area of the plan the employee may be assigned to or be required to choose a different provider, network, and/or plan.	
Please provide the current plan and the plan that you wish to replace it with.	
Current plan(s)	Requested plan(s) upon anniversary effective date
Please note that any employees who wish to make plan changes outside of these requested group level plan mappings/assignments must be listed on the next page. Additionally, any member moving to an HMO plan from a PPO plan, must select a new PCP on this document. If you are making a change to a new HMO network and would like to request a new PCP, that is also required on this form.	
For Health Savings Account (HSA) plans Do you want Anthem to facilitate opening a HSA Financial Custodian (bank) account? <input type="checkbox"/> Yes, if yes, requires completion of questionnaire. <input type="checkbox"/> No	

Section 3: Please complete this section for any employees who wish to make plan changes.

HMO plans: provide three- or six-digit Primary Care physician no. This number can be found on Anthem.com/ca Choose the Find Care link.

Would you like to offer infertility benefits? Yes No

If yes, an additional \$90 will be charged for each subscriber within the group. This applies to all areas, gender and age.

Member name		Social Security no.* or ID no.		Plan name or contract code		PCP no.	
Network option (required)		<input type="checkbox"/> Prudent Buyer PPO <input type="checkbox"/> Select PPO		<input type="checkbox"/> CaliforniaCare HMO <input type="checkbox"/> Select HMO		<input type="checkbox"/> Priority Select HMO <input type="checkbox"/> Vivity	

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Section 4: Be sure to complete this section to authorize your changes.

By signing below, I consent and acknowledge that plan changes may result in rate and benefit changes.

I am an owner or officer of this company, and hereby authorize the following changes to our Anthem group medical policy.

Signature		Print Name		Date (MM/DD/YYYY)	
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* Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.