



Capitol Association Plans
P.O. Box 3040, Fair Oaks, CA 95628-9403

Phone: (916) 944-1707 Fax: (866) 334-5346
E-mail: caps@capsplans.com

CHANGE REQUEST FORM rev. 11/07

IMPORTANT, PLEASE NOTE: For changes to reflect on the next billing, Change Request Form must be received by the 1st of the month.
(All applicable sections must be completed in order to process your change)

A) GROUP NAME		ACCOUNT NUMBER					
B) ELIGIBLE EMPLOYEE/ PERSON APPLYING FOR COVERAGE							
Last Name, First Name		Social Security #		Birth Date	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Dependent Children? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Date of Hire	Effective Date of Change or Termination	Policy(ies) <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Health (if billed by CAPS) <input type="checkbox"/> Life (if billed by CAPS)		Plan Type <input type="checkbox"/> Voluntary (Individual Plan) <input type="checkbox"/> DeltaCare <input type="checkbox"/> DeltaPremier <input type="checkbox"/> VSP Plan B <input type="checkbox"/> Non-Voluntary (Employer Paid Plan)		Hours Worked Per Week	COBRA Coverage <input type="checkbox"/> Request Election Info <input type="checkbox"/> Decline Election Info
Terminate Employee/Personal Coverage <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Covered By Separate Policy <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> Retirement <input type="checkbox"/> Death of Employee		Add Employee/Personal Coverage <input type="checkbox"/> New Employee (For non-voluntary dental, coverage will begin after 6 full months from date of employment) <input type="checkbox"/> Part-time to Full-time <input type="checkbox"/> Loss of Coverage (must provide proof with request for add)		Add Dependent Coverage <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Loss of Coverage (must provide proof with request for add)		Terminate Dependent Coverage <input type="checkbox"/> Divorce or Legal Separation <input type="checkbox"/> Change of Child's Dependent Status	
Employee/ Personal Mailing Address: _____ City: _____ State: _____							
Home Phone: _____ Home Fax: _____ Home Email: _____							
C) DEPENDENTS (When adding or deleting dependents, please also complete eligible employee & employer information above – Sections A & B)							
Spouse Name		<input type="checkbox"/> Add <input type="checkbox"/> Delete	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	Marriage/ Divorce Date	Social Security #	
Child Name		<input type="checkbox"/> Add <input type="checkbox"/> Delete	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	If child 19 years or older <input type="checkbox"/> Full-Time Student (must send proof of enrollment) <input type="checkbox"/> Disabled	Social Security #	
Child Name		<input type="checkbox"/> Add <input type="checkbox"/> Delete	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date	If child 19 years or older <input type="checkbox"/> Full-Time Student (must send proof of enrollment) <input type="checkbox"/> Disabled	Social Security #	

Employee Signature: _____ Date: _____