**Office Use Only:** EFF _____ CARRIER CHG _____ CAPS BILL _____ CARRIER BILL _____ COBRA_____

**Capitol Association Plans**
**P.O. Box 214190, Sacramento, CA 95821**

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

# CHANGE REQUEST FORM rev. 01/07

**IMPORTANT, PLEASE NOTE: For changes to reflect on the next billing, Change Request Form must be received by the 1st of the month.**

***(All sections must be completed in order to process your change)***

| **A) GROUP NAME (REQUIRED)** | **ACCOUNT NUMBER (REQUIRED)** |
|---|---|
| | |

**B) ELIGIBLE EMPLOYEE/ PERSON APPLYING FOR COVERAGE**

| **Last Name, First Name** | **Social Security #** | **Birth Date** | **Sex** | **Dependent Children?** | **Marital Status** |
|---|---|---|---|---|---|
| | | | ☐ Male<br>☐ Female | ☐ Yes<br>☐ No | ☐ Single ☐ Married<br>☐ Divorced ☐ Separated |

| **Add Employee** | **Date of Hire** | **Add Dependent Coverage** | **Terminate Employee/Personal Coverage** | **Terminate Dependent Coverage** | **COBRA Coverage *** |
|---|---|---|---|---|---|
| ☐ New Employee ***(Non-Voluntary Coverage will begin after 6 full months from date of employment)***<br>☐ Part-time to Full-time<br>☐ Loss of Coverage ***(must provide proof with request for add)*** | **Hours worked Per Week** | ☐ Birth<br>☐ Marriage<br>☐ Loss of Coverage ***(must provide proof with request for add)***<br>☐ Attained Age 4 (Dental) | ☐ Termination of Employment<br>☐ Covered By Separate Policy<br>☐ Reduction in Hours<br>☐ Retirement<br>☐ Death of Employee | ☐ Divorce or Legal Separation<br>☐ Change of Child's Dependent Status | ☐ Request Election Info<br>☐ Decline Election Info<br>* **CAL COBRA ONLY** |

| **Effective Date of** | **Plan Type** | **Plan Type** | **Policy(ies)** | **Other** |
|---|---|---|---|---|
| ☐ **Enrollment**<br>☐ **Termination**<br>☐ **Change**<br>**Date:** | ☐ Voluntary (Individual Plan)<br>☐ DeltaCare HMO - Provider ID#:<br>☐ Delta Dental Premier<br>☐ VSP Plan B ☐ Superior Vision Plan B | ☐ Non-Voluntary (Employer Paid-Plan)<br>☐ Delta Dental PPO<br>☐ VSP Plan A<br>☐ Superior Vision Plan A | ☐ Dental<br>☐ Vision | ☐ **Name Change**<br>☐ **Change of Address** |

Employee/ Personal Mailing Address: _____ City: _____ State: _____ Zip: _____

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** | ☐**Add** ☐**Delete** | **Sex** ☐ Male ☐ Female | **Birth Date** | **Marriage/ Divorce Date** | **Social Security #** |
|---|---|---|---|---|---|
| **Child Name** | ☐**Add** ☐**Delete** | **Sex** ☐ Male ☐ Female | **Birth Date** | **If child 26 years or younger** ☐ Full-Time Student ☐ Disabled | **Social Security #** |
| **Child Name** | ☐**Add** ☐**Delete** | **Sex** ☐ Male ☐ Female | **Birth Date** | **If child 26 years or younger** ☐ Full-Time Student ☐ Disabled | **Social Security #** |

**Employee Signature:** _____ **Date:** _____