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 ☐ Female	☐ Yes ☐ No	☐ Single ☐ Married ☐ 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)*** ☐ Part-time to Full-time ☐ Loss of Coverage ***(must provide proof with request for add)***	**Hours worked Per Week**	☐ Birth ☐ Marriage ☐ Loss of Coverage ***(must provide proof with request for add)*** ☐ Attained Age 4 (Dental)	☐ Termination of Employment ☐ Covered By Separate Policy ☐ Reduction in Hours ☐ Retirement ☐ Death of Employee	☐ Divorce or Legal Separation ☐ Change of Child's Dependent Status	☐ Request Election Info ☐ Decline Election Info * **CAL COBRA ONLY**

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