

PacifiCare*
INSTRUCTIONS FOR CHANGE REQUEST FORM

DEADLINE TO CHANGE PLANS IS APRIL 20, 2008

NOTE: If you do not want to change your current plan, you do not need to complete this form. Just pay your current billing statement.

(Remember to attach your business card and this form to your change form.)

MEMBERSHIP INFORMATION Please complete the following information in Black Ink and include this form with your change form **if the change form is not legible it can not be processed:**

MEMBER NAME _____
LOCAL ASSOC. NAME _____
MEMBERSHIP # _____
E-MAIL ADDRESS _____

SELECTING YOUR PLAN: \$10 PCP Co-Pay HMO*
 \$20 PCP Co-Pay HMO*
 \$20 PCP Co-Pay - \$1500 Deductible HMO*
 \$35 PPO Co-Pay - \$1000 Deductible PPO
 *PCP – Primary Care Physician

CHANGING: Add/ Delete Dependent Change Dependent Status
 Name Change Change of Address

COMPLETING CHANGE FORM: **USE BLACK INK AND COMPLETE ALL APPLICABLE SECTIONS**
 (DO NOT COMPLETE THE EMPLOYER SECTION)

REVIEW APPLICATION: **Review the change form for accuracy, sign and date.** Return the change form to us with your first month's premium (made payable to The Benefits Store Trust Account.)

Change Request Forms without the first month's premium will not be processed.

EFFECTIVE DATE OF COVERAGE Change forms are accepted (must be received in our office) no later than April 20, 2008. New Plan Coverage will be effective May 1, 2008.

U.S. MAIL:
ATTN: OPEN ENROLLMENT
Benefits Store, Inc.
PO Box 68, Orinda, CA 94563-0068

OVERNIGHT DELIVERY ONLY
ATTN: OPEN ENROLLMENT
Benefits Store, Inc.
85 High Eagle Road, Alamo, CA 94507-2009

CHANGE FORM PROCESSING Allow 12 business days for processing of your change form, transmission to PacifiCare and data entry before your change will appear in PacifiCare's database.

BILLING QUES. **E-Mail: Billing@BenefitsStore.com**

*This program is a special benefit for members of local Realtor® Associations within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your local Association, The Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.

CHANGE REQUEST FORM

Important: Please print or type all sections in black ink

| Current Personal Information | | | | |
|---------------------------------|--|--------------------|------|-------------------------|
| PacifiCare ID # (if applicable) | | Employer Name | | Group # (if applicable) |
| Last Name | | First Name | | MI Social Security # |
| Address | | Apt # | City | State ZIP |
| Home Telephone () | | Work Telephone () | | Extension |

Change of Personal Information

- Change my address/phone as indicated above.
- Change my name as shown above. My former name was _____

Change of Dependent Status

Newborn, adoption, marriage, open enrollment, other

| | | | | |
|---|---|---------------|------------------------------------|---|
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | Relationship | Last Name | Date of Birth (Month - Day - Year) | Effective Date of Coverage |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | First Name MI | PCP or Medical Group Number | Reason <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other* |
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | Relationship | Last Name | Date of Birth (Month - Day - Year) | Effective Date of Coverage |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | First Name MI | PCP or Medical Group Number | Reason <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other* |

* For "Other," please attach a letter of explanation.

Change of Other Insurance Carrier Information

| | | | | |
|---|---------------|------------------------------------|---------------------------|---------------------------------|
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | Last Name | Social Security Number | Health Coverage Name | Other Employer Name and Address |
| | First Name MI | Date of Birth (Month - Day - Year) | Policy No./Effective Date | |
| <input type="checkbox"/> Add <input type="checkbox"/> Delete | Last Name | Social Security Number | Health Coverage Name | Other Employer Name and Address |
| | First Name MI | Date of Birth (Month - Day - Year) | Policy No./Effective Date | |

Change of Plan Type

Plan changes can only be made during open enrollment. Before you change your plan, please confirm that your employer offers these plans. All family members must be in the same plan.

From (check one)

- PacifiCare SignatureValueSM (HMO)
- PacifiCare SignaturePOSSM
- PacifiCare SignatureOptionsSM (PPO)*
- PacifiCare SignatureIndependenceSM (Indemnity)*
- PacifiCare SignatureFreedomSM (SDHP)*

To (check one)

- PacifiCare SignatureValueSM (HMO)
- PacifiCare SignaturePOSSM
- PacifiCare SignatureOptionsSM (PPO)*
- PacifiCare SignatureIndependenceSM (Indemnity)*
- PacifiCare SignatureFreedomSM (SDHP)*

If you are changing your plan type from a PPO or Indemnity plan to an HMO or POS plan, complete the "Change of Primary Care Physician" section on the reverse of this form.

Signature required for all changes on reverse side of form

| | | |
|---------------|-------------------|-------------------------|
| Employee Name | Social Security # | Group # (if applicable) |
|---------------|-------------------|-------------------------|

Change of Primary Care Physician (PCP)/Medical Group (HMO/POS Only)**

If your change request is received by PacifiCare by the 15th of the month, the change will be effective the first of the following month; if your request is received by PacifiCare after the 15th of the month, the change will be effective the first day of the subsequent month. For Example: If your PCP change request is received January 14, the change is effective February 1. If your request is received January 20, the change is effective March 1. Some restrictions apply. Please ask your employer or call PacifiCare's Customer Service department.

PCP Selection (HMO/POS Only)

Complete this "PCP Selection" section if you are changing your plan type to an HMO or POS plan from a PPO or Indemnity plan, or if you are currently enrolled in an HMO or POS plan and want to change your current PCP.

- You may choose a different doctor for each member of your family.
- Did you select a doctor? If not, we will select one for you.
- Newborns remain enrolled with the mother's PCP from birth until discharged from the hospital. Please refer to your *Combined Evidence of Coverage and Disclosure Form* for further details.

- Please select a doctor near your home for you and each of your family members from your PacifiCare *Provider Directory* and write the name and number below.
- Please indicate your first and second choice.

Note: Over age dependents require proof of full-time student status or permanent disability within 31 days of enrollment. Form cannot be processed if information is incomplete.

| | | | | | | | |
|----------|--|---------------|------------------------------------|-----------------------------|----------------------------|-------------------------------------|--|
| 1 | Self | Last Name | Social Security Number | Primary Care Physician Name | PCP # - OR - Group # | Primary Care Physician (PCP) Number | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | First Name MI | Date of Birth (Month - Day - Year) | Medical Group Name | | Medical Group Number | |
| 2 | Spouse | Last Name | Social Security Number | Primary Care Physician Name | PCP # - OR - Group # | Primary Care Physician (PCP) Number | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | First Name MI | Date of Birth (Month - Day - Year) | Medical Group Name | | Medical Group Number | |
| 3 | Relationship | Last Name | Social Security Number | Primary Care Physician Name | PCP # - OR - Group # | Primary Care Physician (PCP) Number | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | First Name MI | Date of Birth (Month - Day - Year) | Medical Group Name | | Medical Group Number | |
| 4 | Relationship | Last Name | Social Security Number | Primary Care Physician Name | PCP # - OR - Group # | Primary Care Physician (PCP) Number | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | <input type="checkbox"/> Female <input type="checkbox"/> Male | First Name MI | Date of Birth (Month - Day - Year) | Medical Group Name | | Medical Group Number | |

**All medical group changes must be approved by PacifiCare before becoming effective. All ongoing medical care being received from referral providers must be discontinued by the effective date of your medical group change. Please have your condition evaluated by your new primary care physician.

Signature – Required for all changes

| | |
|--|----------------------|
| Your Signature | Date |
| Employer Verification/Authorized Signature | Phone # () |
| | Date |

PacifiCare Use Only

| | | |
|--------------------|-------------|---------------|
| PAC Effective Date | Verified By | Date Verified |
|--------------------|-------------|---------------|

**PacifiCare SignatureValueSM (HMO)
and PacifiCare SignaturePOSSM (POS)**
5701 Katella Avenue
Cypress, CA 90630
Attn: Membership Accounting
800-624-8822 – HMO
800-913-9133 – POS
www.pacificare.com

**PacifiCare SignatureOptionsSM (PPO),
PacifiCare SignatureIndependenceSM (Indemnity)
and PacifiCare SignatureFreedomSM (SDHP)**
P.O. Box 6098
Cypress, CA 90630
866-316-9776 – PPO/Indemnity
866-867-0700 – SDHP
www.pacificare.com