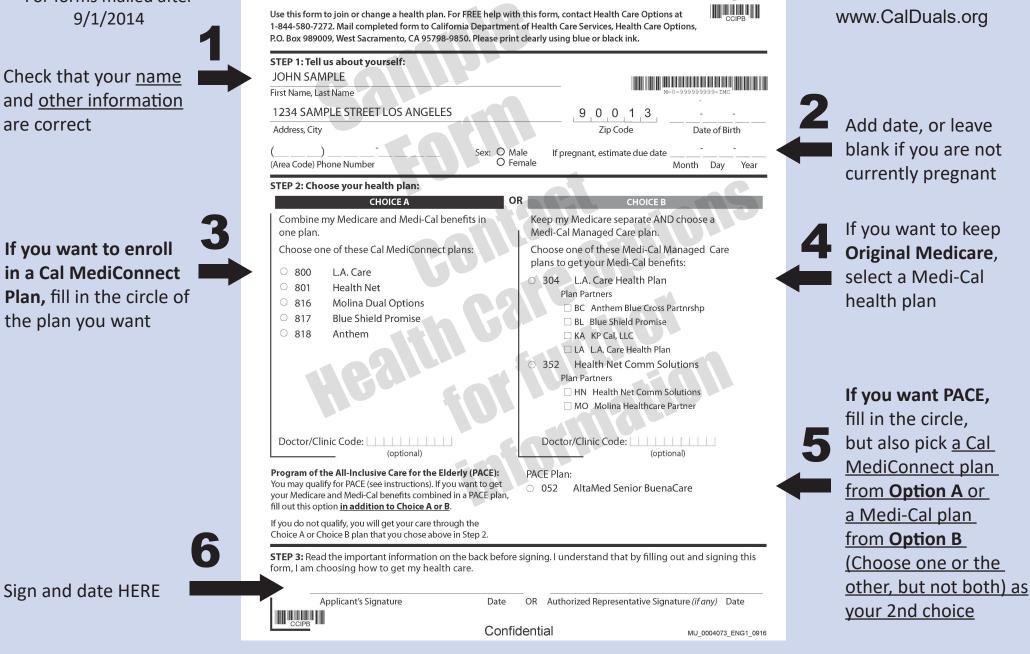
## **Choice Form** Instructions

For forms mailed after 9/1/2014

Check that your name and other information are correct

If you want to enroll in a Cal MediConnect **Plan,** fill in the circle of the plan you want



California Department of Health Care Services

W. Sacramento, CA 95798-9850

P.O. Box 989009

**Health Plan Choice Form** 

CalMedi

Los Angeles County's Choice Form is shown above. Health plans in your county may be different.