COBRA Continuation of Coverage Application

blue of california

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Employee information

Last name	First name	MI

Social Security number	Blue Shield ID number	Group/section No. (please check your Blue Shield ID card)

Date of qualifying event:	**COBRA effective date:**	**Last date worked:**

Qualifying event (check one)

- ☐ Termination or reduction in covered employee's hours
- ☐ Divorce or legal separation of the covered employee
- ☐ Entitlement to Medicare benefits by covered employee
- ☐ Disqualification of dependent child under the plan
- ☐ Termination or reduction of hours due to disability
- ☐ Death of covered employee

The covered member who qualifies for COBRA must complete this section:

Social Security number	Blue Shield ID number	
Last name	First name	MI
Address		
City	State	ZIP code
Phone number		
Date of birth:	Sex: ☐ Male ☐ Female	Married: ☐ Yes ☐ No
If HMO/POS, please indicate your Personal Physician name:		
IPA/Medical Group name:	Phone number	

Please indicate the existing coverage you wish to continue:

- ☐ Medical Plan Election: _____
- ☐ Dental Plan Election: _____
- ☐ Vision: _____

_____ _____

Signature of qualifying member | Date

List below all dependents eligible for coverage

Only those dependents previously enrolled on the group plan are eligible for coverage under COBRA. To add dependents not previously enrolled on your coverage under the group plan, please see your *Evidence of Coverage* (EOC) or *Certificate of Insurance* (COI) booklet for the appropriate provisions.

Relation	Last name	First name	Date of birth:
Other health coverage? ☐ Yes ☐ No	**If HMO/POS** physician name: IPA/MG name/number:		Social Security number:
Relation	Last name	First name	Date of birth:
Other health coverage? ☐ Yes ☐ No	**If HMO/POS** physician name: IPA/MG name/number:		Social Security number:
Relation	Last name	First name	Date of birth:
Other health coverage? ☐ Yes ☐ No	**If HMO/POS** physician name: IPA/MG name/number:		Social Security number:

Please return completed form to the appropriate address below based upon the group's size:

For employer groups with less than 50 employees:
Mail completed form to:
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: (209) 367-6475

For employer groups with more than 50 employees:
Mail completed form to:
Blue Shield of California
P.O. Box 629014
El Dorado Hills, CA 95762-9014
Fax: (916) 350-8800