

1-100 Small Group Information Change Form



Use this form for:

- Notification of terminations of employees/dependents
- Address changes
- COBRA/Cal-COBRA notifications
 - COBRA is for groups with 20 or more employees
 - Cal-COBRA is for groups with 2 to 19 full-time and part-time employees

Note: Credit for deletions will appear on a subsequent bill. (Do not send this form with payment.)

Section 1: Employer information

Employer name		Group/Case no.
Name of person completing form	Email address	Phone no.
Signature X		Date signed

Section 2: Terminating employees

Please submit deletions as they occur. **Retroactive cancellations are not allowed.**

Note: If the employee is Federal COBRA-eligible, please be sure the employee has elected COBRA before checking "Yes" to "Start Federal COBRA." Please refer to Federal COBRA Guidelines in regard to Federal COBRA eligibility.

Social Security no. ¹ or ID no.	Employee name (Last name, first name)	Date of birth	Termination date (Last day worked)	Offer Cal-COBRA?	Cal-COBRA or Federal COBRA qualifying event	Start Federal COBRA?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Employees canceling coverage for themselves or their dependent(s) **must complete** sections A and F of the *Employee Application* or the *Employee Waiver Form*. Please attach the completed application/waiver form declining coverage to this form.

Note: Federal COBRA-eligible dependent must complete an application to enroll on Federal COBRA.

Social Security no. ¹ or ID no.	Employee name (Last name, first name)	Date of birth	Check one	Coverage to be deleted	Is dependent electing Federal COBRA?	Reason for cancellation	Cancellation effective date
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life/Disability <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		

¹ Anthem Blue Cross is required by the Internal Revenue Service and the Centers for Medicare and Medicaid Services (CMS) to collect this information.

