

# 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 <b>X</b>		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.* 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.* 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		

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

**Section 3: Employee/Employer change of address**

This section should be used for employer and/or member address changes.  
 Note: Employees moving out of state are not eligible for HMO plans.

**A. Employee change of address**

Social Security no.* or ID no.	Employee name (Last name, first name)	Date of birth	New street address	City	State	ZIP code	Phone no.

**B. Employer change of address**

New billing street address	City	State	ZIP code
County	Phone no.	Fax no.	
New local street address	City	State	ZIP code
County	Phone no.	Fax no.	

New email address: \_\_\_\_\_

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**To expedite processing, you may:**  
 Fax form to: 1-855-750-2227 (If faxed, please retain original.)  
 Or  
 Mail form to: Anthem Blue Cross  
 P.O. Box 9062  
 Oxnard, CA 93031-9602