



Blue Shield of California
An Independent Member of the Blue Shield Association



Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

COBRA Application

EMPLOYEE INFORMATION

| | | |
|-----------|------------|----|
| Last Name | First Name | MI |
|-----------|------------|----|

| | |
|---------------------------------------|--|
| Social Security # or Blue Shield ID # | Group/Section Number (Please check your Blue Shield ID Card) |
|---------------------------------------|--|

Date of Qualifying Event: ___/___/___

QUALIFYING EVENT (CHECK ONE)

- | | |
|---|--|
| <input type="checkbox"/> Termination or reduction in covered employee's hours | <input type="checkbox"/> Disqualification of Dependent child under the plan |
| <input type="checkbox"/> Divorce or legal separation of the covered employee | <input type="checkbox"/> Termination or reduction of hours due to disability |
| <input type="checkbox"/> Entitlement to Medicare benefits by covered employee | <input type="checkbox"/> Death of covered employee |

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

| | | | |
|---------------------------------------|---|-------------|---|
| Social Security # or Blue Shield ID # | | | |
| Last Name | First Name | MI | |
| Address | | | |
| City | State | Zip | |
| Phone | If HMO, Please indicate your personal physician: | | |
| | Physician Name: | | Number |
| Date of Birth | Sex | Married | Does qualifying member have other coverage? |
| ___/___/___ | ___M___F | ___Yes___No | ___Yes___No |
| 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 | DOB | ___/___/___ |
| Other Health Coverage? | ___Yes___No | If HMO, Physician Name | Number | |
| Relation | Last Name | First Name | DOB | ___/___/___ |
| Other Health Coverage? | ___Yes___No | If HMO, Physician Name | Number | |
| Relation | Last Name | First Name | DOB | ___/___/___ |
| Other Health Coverage? | ___Yes___No | If HMO, Physician Name | 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
P.O. Box 3008
Lodi, CA, 95240

For employer groups with more than 50 employees:

Mail completed form to
Blue Shield
P.O. Box 629014
El Dorado Hills, CA, 95762-9014