blue of california

COBRA Application

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

Employee information

Last name	First name	MI
Social Security No. or Blue Shield ID No.	Group/section No. (please check your Blue Shield ID card)	

Date of qualifying event: _____/_____/__________

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 No. or Blue Shield ID No.

Last name	First name	MI

Address

City	State	ZIP code

Phone No.

Date of birth: _____/_____/__________	Sex: ☐ Male ☐ Female	Married: ☐ Yes ☐ No

If HMO, please indicate your Personal Physician

Physician name:	Phone No.

Does qualifying member have other coverage? ☐ 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	Date of birth: _____/_____/_______
Other health coverage? ☐ Yes ☐ No	**If HMO,** physician name:		Phone No.
Relation	Last name	First name	Date of birth: _____/_____/_______
Other health coverage? ☐ Yes ☐ No	**If HMO,** physician name:		Phone No.
Relation	Last name	First name	Date of birth: _____/_____/_______
Other health coverage? ☐ Yes ☐ No	**If HMO,** physician name:		Phone No.

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

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