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

Cal-COBRA Take-Over Form

Please return completed form to: Blue Shield of California Cal-COBRA, PO Box 629009, El Dorado Hills, CA 95762-9009.

I hereby elect Blue Shield of California subscriber coverage and/or family coverage for my eligible dependents listed below as may be contracted for by the group contract holder. Blue Shield of California benefits, dues, and contract modifications will be in accordance with the group service contract and as allowed under the California Continuation Benefits Replacement Act (Cal-COBRA, California Senate Bill 719).

EMPLOYEE INFORMATION

Last Name	First Name	MI

Social Security Number	Group/Section Number

Date of Qualifying Event: _____/_____/____

QUALIFYING EVENT (CHECK ONE)

____ Termination or reduction in covered employees 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

QUALIFYING ELECTOR INFORMATION:

Social Security Number
_____

Last Name _____ First Name _____ MI _____

Address
_____

City _____ State _____ Zip _____

Phone
_____

If HMO, Please indicate your personal physician:
Physician Name:_____ Number _____

Date of Birth ___/___/___ Sex ___M ___F Married ___Yes ____No Does Qualifying Elector Have Other Health Coverage? ____ Yes ____No

Signature of Elector:_____ Date:_____

LIST BELOW ALL DEPENDENTS ELIGIBLE FOR COVERAGE
Only those dependents previously enrolled on the group plan are eligible for coverage under Cal-COBRA. To add dependents not previously enrolled on your coverage under the group plan, please see your Evidence of Coverage 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_____

Active Choice plans are underwritten by Blue Shield of California Life & Health Insurance Company.

IMPORTANT INSTRUCTIONS
Please Read Carefully

Under Cal-COBRA, you or your dependents are required, as a condition of receiving benefits, to notify Blue Shield of the following qualifying events **within 60 days** of:

1. The death of the subscriber.
2. The divorce or legal separation of the subscriber from the dependent spouse.
3. The dependent child's loss of dependent status under the health plan.
4. The subscriber's entitlement for benefits under Title XVIII of the United States Social Security Act (Medicare).

Notification must be sent to:

Blue Shield of California
Cal-COBRA
P.O. Box 629009
El Dorado Hills, CA 95762-9009

Failure to notify Blue Shield within the required 60 days will disqualify you from receiving continuation coverage.

Notification of your election to continue coverage must be submitted in writing. Notification must be sent by first-class mail, or other reliable means of delivery, (including personal delivery, express mail, or a private courier company) to Blue Shield of California within the 60 day period following the later of: (1) the date of the qualifying event; (2) the date you were provided notification by Blue Shield of the ability to continue coverage under the group health care services plan by Blue Shield; or (3) the date coverage under the employer's group health care services plan terminates.

You are required to send the first payment by certified mail or other reliable means of delivery (including personal delivery, express mail, or private courier company) to Blue Shield of California within 45 days of the date you provided written notification to Blue Shield of the election to continue coverage. The first dues payment must equal an amount sufficient to pay all required amounts that are due. Failure to submit the correct amount within the 45 day period will disqualify you from continuation coverage.

Blue Shield of California will accept those individuals already on Cal-COBRA coverage from a prior carrier. If an employer changes to a Blue Shield health plan, you may continue Cal-COBRA coverage with Blue Shield for the duration of your Cal-COBRA coverage period based on your original qualifying event.

Should the contract between Blue Shield of California and the employer group terminate prior to the date your continuation coverage would end, you or your dependents may elect to continue Cal-COBRA coverage under the subsequent group health service plan. Additionally, you or your dependents may apply for individual coverage through Blue Shield of California's Individual and Family Plans. In either case, you must enroll and submit payment within 30 days of receiving notification of the termination of the employer's group plan with Blue Shield of California or you will be disqualified from receiving any additional benefits.