NOTICE

COBRA CONTINUATION: FAMILY MEMBERS WHO WERE NOT COVERED UNDER YOUR PREVIOUS GROUP PLAN MAY NOT BE ADDED UNTIL OPEN ENROLLMENT

EMPLOYER: COMPLETE TOP SECTION, THEN PROVIDE FORM TO COBRA ELIGIBLES FOR COMPLETION.

COBRA ENROLLMENT APPLICATION

QUALIFYING EVENT:

- ❑ TERMINATION OF EMPLOYMENT
- ❑ REDUCTION OF HOURS
- ❑ DIVORCE/LEGAL SEPARATION FROM EMPLOYEE
- ❑ CHILD NO LONGER ELIGIBLE
- ❑ MEDICARE ENTITLEMENT
- ❑ DEATH OF EMPLOYEE

DATE OF QUALIFYING EVENT:

DATE OF ELECTION:

Employee Last Name

Employee Social Security Number

Employee First Name

California*Choice* Group #

COBRA ENROLLEE: COMPLETE ALL SECTIONS BELOW (Please make all payments payable to COBRA*PRO*, our COBRA Premium Administrator)

Applicant Last Name

Applicant Social Security Number

Applicant First Name

RELATIONSHIP(S) TO EMPLOYEE:

❑ SELF ❑ SPOUSE ❑ CHILD(REN)

PLEASE LIST ONLY THOSE INDIVIDUALS TO BE ENROLLED:

	Last Name	First Name	Middle Initial	Sex (M/F)	Social Security Number	Birth Date (Mo/Day/Yr)	Full Time Student?	✓ if continuing MEDICAL under COBRA	✓ if continuing DENTAL under COBRA	✓ if continuing CHIRO under COBRA
YOU					— —	/ /				
SPOUSE					— —	/ /				
CHILDREN					— —	/ /	❑Yes ❑No			
					— —	/ /	❑Yes ❑No			
					— —	/ /	❑Yes ❑No			

LIST THE NAMES OF ENROLLED INDIVIDUALS WHO ARE ENTITLED TO MEDICARE*:

____

PLEASE COMPLETE THIS SECTION ONLY IF ANY ENROLLED INDIVIDUALS HAVE OTHER ACTIVE GROUP MEDICAL COVERAGE

NAME	COMPANY	POLICY #	EFFECTIVE DATE

YOUR ADDRESS ____

CITY ________________ STATE ______ ZIP ________ DAYTIME PHONE NUMBER (_____) ________________

PLEASE READ AND SIGN BELOW

I hereby apply for continuation of my coverage and those eligible members of my family listed above in the group health plan provided through California*Choice* for which I was covered on the date of termination of coverage. I understand that I must immediately notify the employer from whom I obtained continuation of coverage upon: becoming covered under any other group healthplan; becoming eligible for Medicare benefits; or if, as a former spouse of the subscriber, I remarry and become covered under the new spouse's group healthplan. I understand that it is my responsibility to report to California*Choice* any change in the eligibility of my dependents; that the benefits and services of this plan are coordinated with those provided by any group hospital or medical benefit or service plan; and that any controversy between any Member and Healthplan (including its agents, staff physicians, employees and providers) involving a claim in tort, contract or otherwise, is subject to binding arbitration.

________________________ APPLICANT SIGNATURE

____________ DATE

PLEASE RETURN COMPLETED FORM TO HEALTH PLAN ADMINISTRATOR

CALIFORNIA*CHOICE* STAFF USE

APP. RECEIVED	
EFFECTIVE DATE	
EMPLOYEE #	
PROCESSED	

*Employee is entitled to Medicare if age 65 or over and receives or has applied for Social Security Benefits.

CaliforniaChoice
Your Health. Your Choice.

Cal-COBRA

DEPENDENT QUALIFYING EVENT NOTIFICATION

INSTRUCTIONS: This form must be completed in the event that a dependent of an employee loses health coverage due to:

1) a divorce or legal separation, death of employee or;
2) loss of dependent child status.

To be eligible for CalCOBRA continuation of health benefits, you must complete this form and mail it to California*Choice* within 60 days of one of the events listed above.

1 PLEASE LIST NAME/ADDRESS OF DEPENDENT COMPLETING THIS FORM

Applicant Last Name	Applicant Social Security Number
Applicant First Name	Middle Initial

Applicant Address		
City	State	Zip

Employee Last Name	Employee Social Security Number
Employee First Name	California*Choice* Group #

2 QUALIFYING EVENT INFORMATION

One of the following "qualifying" events has occurred that could entitle a dependent, spouse or ex-spouse of an employee to continuation of health benefits (check one)

- ❒ Divorce or legal separation between employee and spouse
- ❒ Dependent child has lost coverage due to child ceasing to qualify as a dependent under the plan
- ❒ Death of employee
- ❒ Medicare entitlement of employee

TODAY'S DATE	DATE OF QUALIFYING EVENT*	WAS COVERED DEPENDENT DISABLED AT TIME OF THE QUALIFYING EVENT? ❒ Yes ❒ No

**Current coverage will be terminated on the last day of the month in which qualifying event occurred.*

3 QUALIFYING BENEFICIARY INFORMATION

Name of dependent(s) affected by the qualifying event (lost health coverage) and their relationship to the employee

NAME	DATE OF BIRTH	RELATIONSHIP (e.g. SPOUSE, CHILD, ETC)
	/ /	
	/ /	
	/ /	
	/ /	

4 DEPENDENT CERTIFICATION

Please provide me with the forms necessary to elect continuation of health coverage. I understand that notification must be made to California*Choice* within 60 days of the "qualifying event." I hereby certify that the information above is true and correct to the best of my knowledge.

SIGNATURE ______________________ DATE ____________

CALIFORNIA*CHOICE* STAFF USE
RECEIVED BY:
DATE RECEIVED:

Send completed form to: **California*Choice* Benefit Administrators**
721 S. Parker, Suite 200
Orange, CA 92868

CC 0600A 12/2001