blue california

COBRA Continuation of Coverage Application

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

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Clear

Employee information

Last name	First name	MI

Social Security number	Blue Shield ID number	Group/section # (please check your Blue Shield ID card)

Date of qualifying event:	COBRA effective date:	Last date worked:

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

Clear

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

Social Security number	Blue Shield ID number	
Last name	First name	MI
Address		
City	State	ZIP code
Phone number		
Date of birth:	Sex: ☐ Male ☐ Female	Married: ☐ Yes ☐ No

If HMO/POS, please indicate your primary care physician name:

Please tell us about yourself. How would you describe your race or ethnicity? Choose all that apply. These questions are optional and are used only to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?
   - ☐ Yes ☐ No
   - ☐ Unknown
   - ☐ Declined

2. If yes, please choose all that apply:
   - ☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano
   - ☐ Puerto Rican ☐ Salvadoran
   - ☐ Other Hispanic, Latino, Spanish:

3. Which race(s) do you identify with? (Please choose all that apply.)
   - ☐ American Indian or Alaska Native
   - ☐ Asian Indian
   - ☐ Black or African American
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Filipino
   - ☐ Guamanian or Chamorro
   - ☐ Hmong
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Native Hawaiian
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ White
   - ☐ Other
   - ☐ Declined
   - ☐ Unknown

If HMO/POS, please indicate your primary care physician name:

IPA/medical group name:	Phone number

Please indicate the existing coverage you wish to continue:

Medical plan election: _____ Dental plan election: _____

Vision: _____

_____ _____

Signature of qualifying member Date

List below all dependents eligible for coverage

Clear

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/POS** primary care physician name: IPA/MG name/number:		Social Security number:

Please tell us about yourself. How would you describe your race or ethnicity? Choose all that apply. These questions are optional and are used only to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?
☐ Yes ☐ No
☐ Unknown
☐ Declined

2. If yes, please choose all that apply:
☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano
☐ Puerto Rican ☐ Salvadoran
☐ Other Hispanic, Latino, Spanish:

3. Which race(s) do you identify with? (Please choose all that apply.)
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian
☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
☐ Other ☐ Declined ☐ Unknown

Relation	Last name	First name	Date of birth:
Other health coverage? ☐ Yes ☐ No	If **HMO/POS** primary care physician name: IPA/MG name/number:		Social Security number:

Please tell us about yourself. How would you describe your race or ethnicity? Choose all that apply. These questions are optional and are used only to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?
☐ Yes ☐ No
☐ Unknown
☐ Declined

2. If yes, please choose all that apply:
☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano
☐ Puerto Rican ☐ Salvadoran
☐ Other Hispanic, Latino, Spanish:

3. Which race(s) do you identify with? (Please choose all that apply.)
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian
☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
☐ Other ☐ Declined ☐ Unknown

Relation	Last name	First name	Date of birth:
Other health coverage? ☐ Yes ☐ No	If **HMO/POS** primary care physician name: IPA/MG name/number:		Social Security number:

Please tell us about yourself. How would you describe your race or ethnicity? Choose all that apply. These questions are optional and are used only to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?
☐ Yes ☐ No
☐ Unknown
☐ Declined

2. If yes, please choose all that apply:
☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano
☐ Puerto Rican ☐ Salvadoran
☐ Other Hispanic, Latino, Spanish:

3. Which race(s) do you identify with? (Please choose all that apply.)
☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American
☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro
☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian
☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
☐ Other ☐ Declined ☐ Unknown

Please return completed form to the appropriate address below based upon the group's size:

For employer groups with less than 100 employees:
Email or mail completed form to:
small.group@blueshieldca.com
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: (855) 808-8598

For employer groups with 100+ employees:
Mail completed form to:
Blue Shield of California
P.O. Box 629014
El Dorado Hills, CA 95762-9014
Fax: (916) 350-8800