



**HMO COBRA APPLICATION**

- Please print firmly
- Do not write in shaded area
- Please return completed form to your employer

**EMPLOYEE INFORMATION**

LAST NAME				FIRST NAME				MI
SOCIAL SECURITY NUMBER	GROUP/BILLING UNIT NUMBER			NUMBER OF YEARS EMPLOYED AT THIS GROUP PRIOR TO COBRA QUALIFYING EVENT				

**QUALIFYING EVENT (Check One)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Death of covered employee                           | <input type="checkbox"/> Entitlement to Medicare benefits by covered employee | <input type="checkbox"/> Retiree under Chapter 11                            |
| <input type="checkbox"/> Termination or reduction in covered employee hours  | <input type="checkbox"/> Disqualification of Dependent child under the plan   | <input type="checkbox"/> Termination or reduction of hours due to disability |
| <input type="checkbox"/> Divorce or legal separation of the covered employee |   |  |

Is this application for First time COBRA coverage or an Extension of existing coverage?  1st Time  Extension

DATE OF QUALIFYING EVENT    SIGNATURE OF EMPLOYER \_\_\_\_\_ DATE \_\_\_\_\_

**QUALIFYING SUBSCRIBER INFORMATION**

SOCIAL SECURITY NO.		DO NOT WRITE IN SHADED AREAS				GR	BU		
LAST NAME			FIRST NAME			MI	CLERK #	RUNDATE	
ADDRESS						OED	RSN		
						NP	TOC		
CITY			STATE	ZIP					
DATE OF BIRTH	SEX	MARRIED	DOES QUALIFYING SUBSCRIBER HAVE OTHER HEALTH COVERAGE?			YES	NO	X	R
MO	DAY	YR	M	F	YES	NO			

**X** \_\_\_\_\_  
SIGNATURE OF QUALIFYING SUBSCRIBER DATE \_\_\_\_\_

**YOU MUST SELECT A PERSONAL PHYSICIAN**

From the list of Personal Physicians in your Blue Shield Physician Directory for yourself and each of your eligible dependents. You may choose the same or a different Blue Shield Personal Physician for each family member.

Relation	First Name	Personal Physician Name	Physician Number	City Where The Physician Is Located
SELF				

**LIST BELOW ALL DEPENDENTS ELIGIBLE FOR COVERAGE (If more space is required, use additional sheet)**

Relationship to You	Sex	First name	MI	Last name	Date of Birth Mo. Day Year
		PERSONAL PHYSICIAN NAME	PERSONAL PHYSICIAN NAME		CITY PHYSICIAN LOCATED IN
		PERSONAL PHYSICIAN NAME	PERSONAL PHYSICIAN NAME		CITY PHYSICIAN LOCATED IN
		PERSONAL PHYSICIAN NAME	PERSONAL PHYSICIAN NAME		CITY PHYSICIAN LOCATED IN
		PERSONAL PHYSICIAN NAME	PERSONAL PHYSICIAN NAME		CITY PHYSICIAN LOCATED IN