COBRA Enrollment Application

www.calchoiceplus.com

Application must be COMPLETED in FULL, SIGNED and DATED for processing

EMPLOYER: Complete section below—then provide form to COBRA eligibles for completion

QUALIFYING EVENT:

- ❑ Involuntary Termination
- ❑ Resignation
- ❑ Reduction of Hours
- ❑ Death Of Employee
- ❑ Medicare Entitlement
- ❑ Child No Longer Eligible
- ❑ Divorce/Legal Separation from Employee

Date Of Qualifying Event:

Date Of Election:†

Employee Last Name

Employee Social Security Number

Employee First Name

California*Choice* 51+ Group #

† Date of Election is the date of postmark, fax, or other delivery means when the applicant returned this form.

COBRA ENROLLEE: Complete all sections below

Applicant Last Name

Applicant Social Security Number

Applicant First Name

RELATIONSHIP TO EMPLOYEE:

❑ Self ❑ Spouse ❑ Child(ren)
❑ Domestic Partner

Your Address (required) | Apt # | City | State | Zip Code

Daytime Phone number ( ) | Email Address | Mailing Address *(if different from above)*

Please list only those individuals to be enrolled:

	Last Name	First Name	Middle Initial	Relationship to Employee	Social Security Number	Birth Date (Mo/Day/Year)	✓ for Medical	✓ for Dental	✓ for Vision	✓ for Chiro
YOU					— —	/ /				
SPOUSE				❑ Spouse ❑ Domestic Partner — Sex M / F (circle one)	— —	/ /				
CHILDREN				❑ Son ❑ Daughter	— —	/ /				
				❑ Son ❑ Daughter	— —	/ /				
				❑ Son ❑ Daughter	— —	/ /				

Please attach another sheet if you need more space to list dependents. COBRA coverage is only available to those persons who were enrolled on the policy the day before the Qualifying Event occurred. Newly eligible dependents must be added within 30 days of becoming eligible (date of birth/adoption or date of marriage/domestic partnership). Dental, Chiro and Vision are only available to you if the employer group offers them. If you check off a column that the group does not offer, or that you were not enrolled on prior to your Qualifying Event date, you will not be enrolled on that coverage under COBRA.

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* **51+** for which I was covered on the date prior to the Qualifying Event. I understand that I must immediately notify the employer from whom I obtained continuation of coverage upon: becoming covered under any other group health plan; 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 health plan. I understand that it is my responsibility to report to California*Choice* **51+** 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 health plan (including its agents, staff physicians, employees and providers) involving a claim in tort, contract or otherwise, is subject to binding arbitration.

PLEASE RETURN COMPLETED FORM TO YOUR PREVIOUS EMPLOYER

Applicant Signature

Date

COBRA Dependent Qualifying Event Notification

****THIS IS NOT AN APPLICATION FOR COBRA COVERAGE (SEE REVERSE SIDE)****

CaliforniaChoice 51+
Your Health. Your Choice.®
www.calchoiceplus.com

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

- A divorce or legal separation
- Death of the employee
- Medicare entitlement of the employee
- Loss of dependent child status

You must complete this form and mail it to California*Choice* **51+** within 60 days of one of the events listed above.

Employee Information

Employee Last Name

Employee Social Security Number

Employee First Name

California*Choice* 51+ Group #

Please list name/address of the DEPENDENT eligible for continuation of coverage

Dependent Last Name

Dependent Social Security Number

Dependent First Name

Middle Initial

Your Address (required)	Apt #	City	State	Zip Code

Daytime Phone number	Email Address	Mailing Address *(if different from above)*
( )		

Qualifying Event Information

One of the following Qualifying Events has occurred that could entitle a dependent or spouse/domestic partner 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 if this form is received within 60 days of the Qualifying Event.*

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
	/ /	❒ Spouse ❒ Domestic Partner Sex: M / F (circle one)
	/ /	❒ Son ❒ Daughter
	/ /	❒ Son ❒ Daughter
	/ /	❒ Son ❒ Daughter

Certification

I understand that notification must be made to California*Choice* **51+** within 60 days of the Qualifying Event. I hereby certify that the information above is true and correct to the best of my knowledge.

Send completed form to:
California*Choice* **51+**
P.O. Box 7085
Orange, CA 92863-7085

Signature

Date