

Employer Notification of Qualifying Event Under the California Continuation Benefits Replacement Act ("Cal-COBRA")

This notification must be completed by any Employer who is subject to the requirements of Cal-COBRA whenever an Employee loses coverage due to termination of employment or reduction in hours worked.

As required by Health and Safety Code Section 1366.25(a), this notification must be provided to SafeGuard Dental and Vision within 30 days of the date coverage is lost.

SafeGuard Dental and Vision
P.O. Box 30910
Laguna Hills, CA 92654-0910

Employer Name				Group Number	
Employer Address			City (Spell out)		State Zip Code
Employer Phone Number ()			Employer Fax Number ()		
Qualified Beneficiary's Last Name		First Name		MI	Social Security Number
Qualified Beneficiary's Address			City (Spell out)		State Zip Code
Date Coverage Terminates					
Month		Day		Year	
□ □		□ □		□ □ □ □	
Qualifying Event (Check one) <input type="checkbox"/> Termination <input type="checkbox"/> Reduction in hours of employment <input type="checkbox"/> Dependent status					
<input type="checkbox"/> Other, please specify _____					
Employer's Signature					Date

SafeGuard Dental and Vision services are provided by SafeGuard Health Plans, Inc., and SafeHealth Life Insurance Company, where applicable.