

## Blue Shield of California Employer Notification of Qualifying Event Under Cal-COBRA

For employers with 2-19 eligible employees (2-19 employees on payroll)

**Employer:** Complete and return to Blue Shield of California each time a covered employee has a qualifying event which causes them to be eligible for continuation coverage under the California Continuation Benefits Replacement Act (Cal-COBRA).

**Return within 30 days of the last day worked or qualifying event date to:**

Blue Shield of California Cal-COBRA, P.O. Box 629009, El Dorado Hills, CA 95762-9009

Phone: (800) 228-9476 Fax: (916) 350-7480

**Please print**

Employer/company name

Group/customer number

Employer/company phone

Employer/company fax

Qualified beneficiary name/covered employee name

Qualified beneficiary/covered employee current address, city, state, ZIP

Blue Shield ID or Social Security number

Date of birth

**Qualifying event (check one)**

**Enter required date**

- |  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> Termination, resignation, or reduction in employee hours                        | Last day worked                 |
| <input type="checkbox"/> Disqualification of dependent child under the plan of:<br>Covered employee name | Qualifying event date<br>ID/SSN |
| <input type="checkbox"/> Divorce or legal separation<br>Covered employee name                            | Qualifying event date<br>ID/SSN |
| <input type="checkbox"/> Entitlement to Medicare benefits by:<br>Covered employee name                   | Qualifying event date<br>ID/SSN |
| <input type="checkbox"/> Death of covered employee<br>Covered employee name                              | Qualifying event date<br>ID/SSN |
| <input type="checkbox"/> Termination of domestic partnership under the plan of:<br>Covered employee name | Qualifying event date<br>ID/SSN |

Group/employer signature and title

Please print signature name

Date