BlueCross of California

TO EXPEDITE PROCESSING, YOU MAY:

FAX FORM TO:
(805) 499-0842
(If faxed, please retain original.)

OR

MAIL FORM TO:
Blue Cross of California
P.O. Box 9062
Oxnard, CA 93031-9062

Group No:

BC Life & Health Insurance Company

Group Name:

USE THIS FORM FOR:
- Notification of terminations of employees/dependents
- COBRA/Cal-COBRA notifications
  - COBRA is for groups of 20 or more
  - Cal-COBRA applies to groups with 2 to 19 full- and part-time employees.
- Leave of Absence notification and/or Address changes

Small Group Information Change Form

Name of Person Completing Form	Signature/Date	Due Date	Phone No. ( )

1. TERMINATING EMPLOYEES

Please submit deletions as they occur. **RETROACTIVE CANCELLATIONS ARE NOT ALLOWED. Note:** If the employee is Federal COBRA-eligible, PLEASE be sure the employee has elected COBRA before checking YES to "Start Federal COBRA." Please refer to Federal COBRA Guidelines in regard to Federal COBRA eligibility.

Social Security or ID No.	Employee Name (Last Name, First Name)	Termination Date	Offer Cal-COBRA? Yes	Offer Cal-COBRA? No	Cal-COBRA or Federal COBRA Qualifying Event*	Start Federal COBRA? Yes	Start Federal COBRA? No
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2. ACTIVE EMPLOYEES DECLINING COVERAGE FOR SELF OR DEPENDENT(S)

Employees cancelling coverage for themselves or their dependent(s) **MUST COMPLETE Sections 2 and 4** of the Employee Application in compliance with California State Law AB 1672. Please attach the completed application declining coverage to this form.
Note: Federal COBRA-eligible dependent **MUST COMPLETE** an application to enroll on Federal COBRA.

Social Security or ID No.	Check One: Employee	Check One: Dependent	Employee or Dependent Name (Last Name, First Name)	Coverage to be Deleted: Medical	Coverage to be Deleted: Dental	Coverage to be Deleted: Life	Is Dependent Electing Federal COBRA? Yes	Is Dependent Electing Federal COBRA? No	Reason for Cancellation	Cancellation Effective Date
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	☐	☐		☐	☐	☐	☐	☐		

3. EMPLOYEE LEAVE OF ABSENCE

This section should be completed for employees who are beginning a medical or personal leave of absence (LOA).

Social Security or ID No.	Employee Name (Last Name, First Name)	Medical LOA	Personal LOA	LOA Start Date	LOA End Date

4. EMPLOYEE/GROUP CHANGE OF ADDRESS

This section should be used for groups and/or member address changes.

Note: The Group MAY experience a rate change upon the address change of an Employee. Employees moving out of state are not eligible for HMO or EPO plans.

A. EMPLOYEE CHANGE OF ADDRESS

Social Security or ID No.	Employee Name (Last Name, First Name)	New Street Address	City/State/ZIP Code

B. GROUP CHANGE OF ADDRESS

New Billing Address	New Local Address	City/State/ZIP Code

NOTE: CREDIT FOR DELETIONS WILL APPEAR ON A SUBSEQUENT BILLING. (DO NOT SEND THIS FORM WITH PAYMENT.)

*SmileNet does not qualify for COBRA or Cal-COBRA.

Blue Cross of California (BCC) and BC Life & Health Insurance Company (BCL&H) are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA. All HMO Medical and Dental plans, Premier $10/$20 Copay plans, PPO $30/$40 Copay plans are offered by BCC. All other Medical, Dental, Term Life and AD&D products and the SmileNet discount program are offered by BCL&H