blue california

Cal-COBRA dental election form

Please return completed form to:
Blue Shield of California Cal-COBRA, PO Box 629009, El Dorado Hills, CA 95762-9009.

I hereby elect Blue Shield of California subscriber dental coverage and/or family coverage for my eligible dependents listed below as may be contracted for by the group contract holder. Blue Shield of California benefits, dues, and contract modifications will be in accordance with the group service dental contract and as allowed under the California Continuation Benefits Replacement Act (Cal-COBRA).

Employee information

Last name	First name	MI

Blue Shield of California ID/SSN	Group/section number	Date of qualifying event

Qualifying event

Check one, enter required date

- ☐ Termination or reduction in covered employee's hours (last day worked) (month, day, year) _____
- ☐ Divorce or legal separation of the covered employee (qualifying event date) (month, day, year) _____
- ☐ Entitlement to Medicare benefits by covered employee (qualifying event date) (month, day, year) _____
  Covered employee name _____ Blue Shield of California ID/SSN _____
- ☐ Disqualification of dependent child under the plan (qualifying event date) (month, day, year) _____
- ☐ Termination or reduction of hours due to disability (last day worked) (month, day, year) _____
- ☐ Death of covered employee (qualifying event date) (month, day, year) _____
- ☐ Termination of domestic partnership (qualifying event date) (month, day, year) _____

Qualifying elector information

Last name	First name	MI	Social Security number

Address (street, city, state, ZIP)	Phone number

Date of birth (month, day, year)	Gender ☐ Male ☐ Female	Married? ☐ Yes ☐ No	Domestic partnership? ☐ Yes ☐ No

Does qualifying elector have other dental coverage? ☐ Yes ☐ No	Does qualifying elector have Medicare? ☐ Yes ☐ No	Does qualifying elector have Medicare due to disability? ☐ Yes ☐ No

If HMO, please indicate your Personal Physician's name	Phone number

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

X _____ Date _____
Signature of elector

X _____
Please print signature name

(see reverse)

List below all dependents eligible for coverage

Only those dependents previously enrolled on the group plan are eligible for coverage under Cal-COBRA. To add dependents not previously enrolled on your coverage under the group plan, please see your *Evidence of Coverage* (EOC) or *Certificate of Insurance* (COI) booklet for the appropriate provisions.

Relationship	Last name	First name	Date of birth (month, day, year)
Other dental coverage? ☐ Yes ☐ No	Medicare? ☐ Yes ☐ No	Medicare due to disability? ☐ Yes ☐ No	Dependent SSN#
If HMO, Physician name			Phone number
Relationship	Last name	First name	Date of birth (month, day, year)
Other dental coverage? ☐ Yes ☐ No	Medicare? ☐ Yes ☐ No	Medicare due to disability? ☐ Yes ☐ No	Dependent SSN#
If HMO, Physician name			Phone number
Relationship	Last name	First name	Date of birth (month, day, year)
Other dental coverage? ☐ Yes ☐ No	Medicare? ☐ Yes ☐ No	Medicare due to disability? ☐ Yes ☐ No	Dependent SSN#
If HMO, Physician name			Phone number

Important instructions (please read carefully)

Under Cal-COBRA, you or your dependents are required, as a condition of receiving benefits, to notify Blue Shield of the following qualifying events within 60 days of:

1. The death of the subscriber.
2. The divorce or legal separation of the subscriber from the dependent spouse.
3. The dependent child's loss of dependent status under the health plan.
4. The subscriber's entitlement for benefits under Title XVIII of the United States Social Security Act (Medicare).

Failure to notify Blue Shield within the required 60 days will disqualify you from receiving continuation coverage.

Notification of your election to continue coverage must be submitted in writing. Notification must be sent by first-class mail, or other reliable means of delivery, (including personal delivery, express mail, or a private courier company) to Blue Shield of California within the 60 day period following the later of: (1) the date of the qualifying event; (2) the date you were provided notification by Blue Shield of the ability to continue coverage under the group health care services plan by Blue Shield; or (3) the date coverage under the employer's group health care services plan terminates.

You are required to send the first payment by certified mail or other reliable means of delivery (including personal delivery, express mail, or private courier company) to Blue Shield of California within 45 days of the date you provided written notification to Blue Shield of the election to continue coverage. The first dues payment must equal an amount sufficient to pay all required amounts that are due. Failure to submit the correct amount within the 45-day period will disqualify you from continuation coverage.

Blue Shield of California will accept those individuals already on Cal-COBRA coverage from a prior carrier. If an employer changes to a Blue Shield health plan, you may continue Cal-COBRA coverage with Blue Shield for the duration of your Cal-COBRA coverage period based on your original qualifying event.

Should the contract between Blue Shield of California and the employer group terminate prior to the date your continuation coverage would end, you or your dependents may elect to continue Cal-COBRA coverage under the subsequent group health service plan. Additionally, you or your dependents may apply for individual coverage through Blue Shield of California's Individual and Family Plans. In either case, you must enroll and submit payment within 30 days of receiving notification of the termination of the employer's group plan with Blue Shield of California or you will be disqualified from receiving any additional benefits.

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