Continuation of coverage application (COBRA and Cal-COBRA)

Form effective April 1, 2024

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

Member: Use this form to apply for continuation coverage (federal COBRA or Cal-COBRA). If you had Cal-COBRA coverage from a prior carrier and your employer changed to a Blue Shield health plan, use the Employee Enrollment Application form to continue Cal-COBRA coverage with Blue Shield for the duration of your Cal-COBRA coverage period based on your original qualifying event.

If electing Cal-COBRA: You hereby elect Blue Shield of California subscriber coverage and/or family coverage for your eligible dependents listed below as may be contracted for by the group contract holder. Blue Shield benefit, dues, and contract modifications will be in accordance with the group service contract and as allowed under Cal-COBRA.

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.

Return within 30 days of the qualifying event date by email or mail, as follows:

Large Group (101+ Employees):
P.O. Box 3008
Lodi, CA 95241-1912
COBRA Email: **LargeGroup.DedicatedProcessors@blueshieldca.com**
Cal-COBRA Email: **clericalcalcobra@blueshieldca.com**

Small Group (1 to 100 Employees):
P.O. Box 3008
Lodi, CA 95241-1912
Email: **small.group@blueshieldca.com**

1 Election reason

Choose one election reason:

☐ Federal COBRA	Large and small groups	New or existing Blue Shield member electing COBRA
☐ Continue group coverage on Cal-COBRA after exhausting federal COBRA	Large and small groups	If you have exhausted coverage under federal COBRA and were not entitled to the maximum period of 36 months or have been covered as a domestic partner and the partnership terminated, you can apply to continue group coverage as allowed under the California Continuation Benefits Replacement Act (Cal-COBRA) if you complete this election form.
☐ Cal-COBRA	Small groups only	Existing Blue Shield members electing Cal-COBRA

2A Group, employee, qualified elector identification

Blue Shield group ID or section number (found on your Blue Shield ID card)

Employee name (first, middle initial, last)	Employee's Blue Shield ID or Social Security number	Gender ☐ Male ☐ Female
Name of qualified elector who is enrolling (first and last)	Qualified elector's Blue Shield ID or Social Security number (if different than employee)	Gender (if different than employee) ☐ Male ☐ Female
Qualified elector street address	City	State ZIP code
Qualified elector email	Qualified elector date of birth	Married? ☐ Yes ☐ No Domestic partnership? ☐ Yes ☐ No

Please copy this page as needed and complete section 2A for additional qualified electors who are enrolling.

2B Qualified elector race and ethnicity

These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

1a. Are you of Hispanic or Latino origin?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Declined

1b. If yes, please select one:

- ☐ Cuban
- ☐ Guatemalan
- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Salvadoran
- ☐ Two or more ethnicities
- ☐ Other Hispanic, Latino, Spanish:

2. Which race do you identify with? Please select one:

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Two or more races
- ☐ Other
- ☐ Unknown
- ☐ Declined

2C Qualified elector product selection

Select all Blue Shield product(s) in which the qualified elector was previously <u>enrolled and</u> chooses to continue coverage.
You may downgrade the plan by entering a new plan name, or leave this line blank to retain coverage in the current plan.

☐ Medical	New plan name (optional)	If new plan, new primary care physician name (optional)
☐ Dental	New plan name (optional)	If new plan, new primary care dentist name (optional)
☐ Vision	New plan name (optional)	If new plan, new primary care optometrist name (optional)

3 Qualifying event details

☐ Yes ☐ No Does the qualifying elector have coverage other than Blue Shield (including Medicare)?

If yes, which products? (select all that apply): ☐ Medical ☐ Dental ☐ Vision

Original qualifying event date	For termination/resignation, the qualifying event date is the last day of employment. For reduction in employee hours, the qualifying event date is the cancellation date. For all others, it's the qualifying event date.

Choose **one** qualifying event:

- ☐ Employee termination, resignation, reduction in hours
- ☐ Entitlement to Medicare benefits by covered employee
- ☐ Death of covered employee
- ☐ Disqualification of dependent child
- ☐ Divorce or legal separation
- ☐ Termination of domestic partnership

4 **Dependents electing coverage** (optional)

Only those dependents previously enrolled on the group plan are eligible for coverage under Cal-COBRA or federal COBRA. To add dependents 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.

Additional dependent

Dependent name (first and last) | Relationship | Dependent Blue Shield ID or Social Security number

Dependent's email | Date of birth (month, day, year)

(Optional) Does the dependent identify with the same race and ethnicity as the qualified elector? ☐ Yes ☐ No
If no, which race and ethnicity does this dependent identify with?

Does the dependent have coverage other than Blue Shield (including Medicare)? ☐ Yes ☐ No
If yes, which products? (select all that apply): ☐ Medical ☐ Dental ☐ Vision

Select all Blue Shield product(s) in which the dependent was previously enrolled, if the dependent would like to continue coverage. If the qualified elector changed plans, provide the dependent's new primary care provider name, if applicable.

☐ Medical
New primary care physician name (optional)

☐ Dental
New primary care dentist name (optional)

☐ Vision

Additional dependent

Dependent name (first and last) | Relationship | Dependent Blue Shield ID or Social Security number

Dependent's email | Date of birth (month, day, year)

(Optional) Does the dependent identify with the same race and ethnicity as the qualified elector? ☐ Yes ☐ No
If no, which race and ethnicity does this dependent identify with?

Does the dependent have coverage other than Blue Shield (including Medicare)? ☐ Yes ☐ No
If yes, which products? (select all that apply): ☐ Medical ☐ Dental ☐ Vision

Select all Blue Shield product(s) in which the dependent was previously enrolled, if the dependent would like to continue coverage. If the qualified elector changed plans, provide the dependent's new primary care provider name, if applicable.

☐ Medical
New primary care physician name (optional)

☐ Dental
New primary care dentist name (optional)

☐ Vision

4 **Dependents electing coverage** (optional) continued

Additional dependent

Dependent name (first and last) | Relationship | Dependent Blue Shield ID or Social Security number

Dependent's email | Date of birth (month, day, year)

(Optional) Does the dependent identify with the same race and ethnicity as the qualified elector? ☐ Yes ☐ No
If no, which race and ethnicity does this dependent identify with?

Does the dependent have coverage other than Blue Shield (including Medicare)? ☐ Yes ☐ No
If yes, which products? (select all that apply): ☐ Medical ☐ Dental ☐ Vision

Select all Blue Shield product(s) in which the dependent was previously enrolled, if the dependent would like to continue coverage. If the qualified elector changed plans, provide the dependent's new primary care provider name, if applicable.

☐ Medical
New primary care physician name (optional)

☐ Dental
New primary care dentist name (optional)

☐ Vision

Additional dependent

Dependent name (first and last) | Relationship | Dependent Blue Shield ID or Social Security number

Dependent's email | Date of birth (month, day, year)

(Optional) Does the dependent identify with the same race and ethnicity as the qualified elector? ☐ Yes ☐ No
If no, which race and ethnicity does this dependent identify with?

Does the dependent have coverage other than Blue Shield (including Medicare)? ☐ Yes ☐ No
If yes, which products? (select all that apply): ☐ Medical ☐ Dental ☐ Vision

Select all Blue Shield product(s) in which the dependent was previously enrolled, if the dependent would like to continue coverage. If the qualified elector changed plans, provide the dependent's new primary care provider name, if applicable.

☐ Medical
New primary care physician name (optional)

☐ Dental
New primary care dentist name (optional)

☐ Vision

Active Choice plans are underwritten by Blue Shield of California Life and Health Insurance Company.

5 Signature

The qualified elector must sign below; if the qualified elector is a dependent age 17 or under, then the employee must sign.

Elector | Date

X _____ _____

Printed signature name

6 **Cal-COBRA 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 healthcare services plan by Blue Shield; or (3) the date coverage under the employer's group healthcare 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 provide 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.

Please do not send payment with submission of this form. Payment will be requested once you receive enrollment confirmation, at which point you will be sent a billing statement.

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.