

EMPLOYER: COMPLETE TOP SECTION, THEN PROVIDE FORM TO COBRA ELIGIBLES FOR COMPLETION.

**QUALIFYING EVENT:**

- Termination Of Employment  
 Reduction Of Hours  
 Divorce/Legal Separation From Employee  
 Child No Longer Eligible  
 Medicare Entitlement\*  
 Death Of Employee

Date Of Qualifying Event:

Date Of Election:<sup>†</sup>



Employee Last Name

Employee Social Security Number

Employee First Name

CaliforniaChoice<sup>®</sup> Group #

<sup>†</sup> Date of Election is the date of postmark, fax, or other delivery means when the applicant returned this form.

\* Employee is entitled to Medicare upon the effective date of enrollment in either Part A or Part B, whichever is earlier.

**COBRA ENROLLEE: COMPLETE ALL SECTIONS BELOW** (Please make all payments payable to CONEXIS, our COBRA Premium Administrator)

Applicant Last Name

Applicant Social Security Number

Applicant First Name

**RELATIONSHIP TO EMPLOYEE:**

- SELF    SPOUSE    CHILD(REN)  
 DOMESTIC PARTNER

**PLEASE LIST ONLY THOSE INDIVIDUALS TO BE ENROLLED:**

	Last Name	First Name	Middle Initial	Relationship to Employee	Social Security Number	Birth Date (Mo/Day/Year)	Full Time Student?	✓ for Medical	✓ for Dental	✓ for Vision	✓ for Chiro
<b>YOU</b>					— —	/ /					
<b>SPOUSE</b>				<input type="checkbox"/> Spouse   Sex <input type="checkbox"/> Domestic Partner   M / F <small>(circle one)</small>	— —	/ /					
<b>CHILDREN</b>				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No				
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Please attach another sheet if you need more space to list dependents. COBRA coverage is only available to those persons who were enrolled on the policy the day before the Qualifying Event occurred. Newly eligible dependents must be added within 30 days of becoming eligible (date of birth/adoption or date of marriage/domestic partnership). Dental, Chiro and Vision are only available to you if the employer group offers them. If you check off a column that the group does not offer, or that you were not enrolled on prior to your Qualifying Event date, you will not be enrolled on that coverage under COBRA.

Your address (required) \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Daytime phone number \_\_\_\_\_ Email \_\_\_\_\_

Mailing address (if different) \_\_\_\_\_

**PLEASE READ AND SIGN BELOW:**

I hereby apply for continuation of my coverage and those eligible members of my family listed above in the group health plan provided through CaliforniaChoice<sup>®</sup> for which I was covered on the date prior to the Qualifying Event. I understand that I must immediately notify the employer from whom I obtained continuation of coverage upon: becoming covered under any other group health plan; becoming eligible for Medicare benefits; or if, as a former spouse of the subscriber, I remarry and become covered under the new spouse's group health plan. I understand that it is my responsibility to report to CaliforniaChoice<sup>®</sup> any change in the eligibility of my dependents; that the benefits and services of this plan are coordinated with those provided by any group hospital or medical benefit or service plan; and that any controversy between any member and health plan (including its agents, staff physicians, employees and providers) involving a claim in tort, contract or otherwise, is subject to binding arbitration.

**PLEASE RETURN COMPLETED FORM TO HEALTH PLAN ADMINISTRATOR**

APPLICANT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

