

2-50 Small Group Employee Information Change Form

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.
- Address changes

| | |
|------------|-----------|
| Group Name | Group No. |
|------------|-----------|

TO EXPEDITE PROCESSING, YOU MAY:

| | | |
|---|-----------|---|
| FAX FORM TO: (805) 499-0842 <i>(If faxed, please retain original.)</i> | OR | MAIL FORM TO: Anthem Blue Cross P.O. Box 9062 Oxnard, CA 93031-9062 |
|---|-----------|---|

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

| | | | |
|--------------------------------|----------------|----------|------------------|
| 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? | | Cal-COBRA or Federal COBRA Qualifying Event | Start Federal COBRA? | |
|---------------------------|--|------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | | | Yes | No | | Yes | No |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |

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 or Dependent Name (Last Name, First Name) | Coverage to be Deleted | | | Is Dependent Electing Federal COBRA? | | Reason for Cancellation | Cancellation Effective Date |
|---------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|-------------------------|-----------------------------|
| | Employee | Dependent | | Medical | Dental | Life | Yes | No | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

3. 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 |
|---------------------|-------------------|---------------------|
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