# COBRA Enrollment Form

| Effective Date | Group No. |
|---|---|
| | |

☐ Federal COBRA (medical and/or dental)
☐ Cal-COBRA AB1401 (medical only)

## APPLICANT'S PERSONAL INFORMATION

| Last Name (Print) | First Name (Print) | M.I. | ☐ Male ☐ Female |
|---|---|---|---|
| Street Address | City | State | ZIP Code |
| Telephone No. ( ) – | Dept. No. | E-mail Address | |

## APPLICANT'S LANGUAGE PREFERENCE

When information is sent to you, we may be able to send it to you in a language other than English. What language would you prefer? (Optional)

☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Japanese ☐ Tagalog ☐ Vietnamese ☐ Khmer ☐ Hmong ☐ Farsi
☐ Arabic ☐ Armenian ☐ Russian ☐ Other _____

## EMPLOYEE & FAMILY INFORMATION – Please list below the family members that were covered under your previou

| | Last Name | First Name | M.I. | Sex | Birthdate Mo/Day/Yr | Age | Social Security No. |
|---|---|---|---|---|---|---|---|
| Self | Same as above | Same as above | | | | | |
| ☐ Spouse ☐ Domestic Partner | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |
| Child | | | | ☐ M ☐ F | | | |

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State purs

## DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete this section inclu

| | Last Name | First Name | Name and Address of Other Insurance Carrier |
|---|---|---|---|
| Self | | | |
| ☐ Spouse ☐ Domestic Partner | | | |
| Dependent No. 1 Above | | | |
| Dependent No. 2 Above | | | |
| Dependent No. 3 Above | | | |
| Dependent No. 4 Above | | | |

**DISTRIBUTION:** **WHITE** – Return this copy;

## TYPE OF COVERAGE: Select the existing benefits you wish to continue:

**Medical**

**Anthem Blue Cross plans:**

- ☐ HMO (CaliforniaCare)*
- ☐ Preferred HMO (CaliforniaCare PLUS)*
- ☐ Advantage HMO*
- ☐ Select HMO*
- ☐ PPO (Prudent Buyer)
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)*
- ☐ Other _____

**Anthem Blue Cross Life and Health Insurance Company plans:**

- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO (non-California resident)
- ☐ Lumenos® (select one of the following)
  - ☐ H.S.A.** ☐ H.R.A. ☐ H.I.A. ☐ H.I.A. Plus
- ☐ Medicare

* Indicate Medical Group/IPA No. in the *Employee & Family Information* section below.

** Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

**Dental**

**Anthem Blue Cross plans:**

- ☐ Dental Net*
- ☐ **Choice Dental** (select one of the following)
  - ☐ Dental Net* ☐ PPO Dental

**Anthem Blue Cross Life and Health Insurance Company plans:**

- ☐ **Dental Blue** (select one of the following)
  - ☐ 100 ☐ 200 ☐ 300 ☐ Complete
- ☐ PPO Dental ☐ National Dental PPO
- ☐ Voluntary PPO ☐ National Voluntary PPO
- ☐ Other _____

* Indicate Dental Office No. in the *Employee & Family* section

**Vision** ☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

COBRA coverage includes: ☐ Employee Only ☐ Employee and Dependent(s) ☐ Dependent(s) Only

| If Enrollee is not (former) employee: | Employee Name | Employee's Social Security No. |
|---|---|---|
| | | |

## group health plan that you wish to continue coverage under either Federal COBRA or Cal-COBRA.

| If children are age 19 or over you must check the appropriate boxes below | | Coverage | Medical Group/IPA No. | Anthem Blue Cross HMO IPA Primary Care Physician Code | Is this your current MD? | Dental Office No. |
|---|---|---|---|---|---|---|
| | | ☐ Medical ☐ Dental ☐ Vision | | | ☐ Yes ☐ No | |
| Qualifies as IRS Dependent | Full-time Student | ☐ Medical ☐ Dental ☐ Vision | | | ☐ Yes ☐ No | |
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Medical ☐ Dental ☐ Vision | | | ☐ Yes ☐ No | |
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Medical ☐ Dental ☐ Vision | | | ☐ Yes ☐ No | |
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Medical ☐ Dental ☐ Vision | | | ☐ Yes ☐ No | |
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Medical ☐ Dental ☐ Vision | | | ☐ Yes ☐ No | |

nt to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

## ng Medicare (if applicable)

| Effective Date Mo/Day/Yr | Group Number |
|---|---|
| | |
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| | |
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| | |
| | |

## MEDICARE SECTION

Are you retired? ..... ☐ Yes ☐ No

If yes ..... Part A .... ☐ Yes ☐ No
Part B .... ☐ Yes ☐ No

Do you or your Dependents have Medicare? ..... ☐ Yes ☐ No

If yes for your dependent Part A .... ☐ Yes ☐ No
Part B .... ☐ Yes ☐ No

Name(s) of Medicare Dependents:

_____

_____

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB No. _____

Entitlement Reason:
☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare: ____ /____ /____

Name _____

HIB No. _____

Entitlement Reason:
☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare: ____ /____ /____

Name _____

**CANARY** – Individual's copy; **PINK** – Employer's copy

## CONTINUATION OF GROUP HEALTH COVERAGE

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

(1) The date eligibility for COBRA Continuation Coverage ends, or

(2) The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or

(3) The date your employer discontinues coverage with Anthem Blue Cross, or

(4) The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or

(5) The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise, unless that other group health plan contains an exclusion or limitation for a pre-existing condition for which you are covered under your current coverage with Anthem Blue Cross. In such a case, the date on which you would lose eligibility for Continuation Coverage with Anthem Blue Cross is the date full coverage becomes available to you under the other plan, without limitations or exclusions for pre-existing conditions.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

**Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.**

**NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

### REQUIREMENT FOR BINDING ARBITRATION

**The following provision does not apply to class actions:**

**IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT.** ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

*Signature (Required)*

| Applicant | Date |
|---|---|
| | |

**ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE NOT YOUR COBRA ADMINISTRATOR. FOR QUESTIONS OR CONCERNS ABOUT YOUR COVERAGE, PLEASE CONTACT THE HEALTH PLAN ADMINISTRATOR AT YOUR PREVIOUS EMPLOYER.**

## GROUP PLAN INFORMATION TO BE COMPLETED BY EMPLOYER AT THE TIME COBRA NOTICE IS PROVIDED TO ENROLLEE

| Company Name | Group Number(s) |
|---|---|
| | |

**Employee:** ☐ Termination of employment ☐ Reduction of employee's work hours
☐ Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees.

**Family Member:** ☐ Death of the employee ☐ Divorce or legal separation from employee ☐ Loss of dependent child eligibility
☐ Employee's entitlement to Medicare
☐ Benefits terminated or reduced within one year before or after retired employee's employer filing bankruptcy, if plan provides benefits for retirees.

| Date of Federal COBRA Qualifying Event | Date of Loss of Coverage | Date When Federal COBRA Continued Coverage Ends | Date Notice Given |
|---|---|---|---|
| | | | |

| Enrollee's Initials Upon Receipt of Notice | Cal-COBRA Effective Date | Date When Cal-COBRA Coverage Ends |
|---|---|---|
| | | |

| Signature | Title of Plan Holder Representative | Telephone No. |
|---|---|---|
| X | | |