



TO EXPEDITE PROCESSING, YOU MAY:
FAX FORM TO: (805) 499-7762
(If faxed, please retain original.) **OR** **MAIL FORM TO:**
 Blue Cross of California
 P.O. Box 9062
 Oxnard, CA 93031-9062



Group No:

Group Name:

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

Small Group Employee Information Change Form

Name of Person Completing Form	Date	Phone No. ()
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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.

Certificate 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"/>

2. 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 AB1672. Please attach the completed application declining coverage to this form.

Certificate No.	Check One:		Employee or Dependent Name (Last Name, First Name)	Coverage to be Deleted			Is Dependent Electing COBRA? If yes, complete Sec. 4		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 CHANGE OF ADDRESS

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.

Certificate No.	Employee Name (Last Name, First Name)	New Street Address	City/State/ZIP Code

4. COBRA-ELIGIBLE DEPENDENTS: PLEASE COMPLETE THIS SECTION IF ENROLLING IN FEDERAL COBRA.

Employee's Certificate No.	Dependent Social Security No. (List eldest dependent first)	Dependent Name (Last Name, First Name)	Effective Date

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