BLUE SHIELD of California

GROUP CONTINUATION COVERAGE (COBRA) Election Form

I hereby elect Blue Shield of California subscriber coverage and family coverage for my eligible dependents listed below as may be contracted for by the group contract holder. Blue Shield of California benefits, dues and contract modifications will be in accordance with the group service contract. I hereby authorize any physician or hospital to disclose to Blue Shield any information obtained by having attended or examined or by hereafter attending or examining me or my family members.

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NUMBER	GROUP/BILLING UNIT NUMBER

QUALIFYING EVENT (CHECK ONE)

- _____ Death of covered employee
- _____ Termination or reduction in covered employee hours
- _____ Divorce or legal separation of the covered employee
- _____ Entitlement to Medicare benefits by covered employee
- _____ Disqualification of Dependent child under the plan
- _____ Retiree under Chapter 11
- _____ Termination or reduction of hours due to disability

DATE OF QUALIFYING EVENT Month | Day | Year

_____ SIGNATURE OF EMPLOYER _____ DATE

QUALIFYING SUBSCRIBER INFORMATION

SOCIAL SECURITY NUMBER	DO NOT WRITE IN SHADED AREAS	GR	BU

LAST NAME	FIRST NAME	MI	CLERK #	RUNDATE

ADDRESS	OED	RSN

	NP	TOC	

CITY	STATE	ZIP

DATE OF BIRTH Mo. Day Yr.	SEX M F	MARRIED Yes No	DOES QUALIFYING SUBSCRIBER HAVE OTHER HEALTH COVERAGE?	YES	NO	X	R

COMPLETE REVERSE SIDE ALSO

X _____ SIGNATURE OF QUALIFYING SUBSCRIBER _____ DATE

CREDIT FOR PRIOR DEDUCTIBLE FOR ORIGINAL EMPLOYEES

Blue Shield of California will credit any previously applied deductibles. If you or any of your dependents have had a deductible applied by the previous carrier **FOR THIS CALENDAR YEAR**, please complete this form and attach photocopies of documents from previous carrier for verification of applied deductibles.

SUBSCRIBER NAME	BLUE SHIELD GROUP NO.	I.D./SOCIAL SECURITY NO.	EFFECTIVE DATE OF COVERAGE

NAME OF GROUP

PLEASE LIST EACH FAMILY MEMBER SEPARATELY
(FORM CONTINUES ON REVERSE SIDE)

PATIENT'S FULL NAME	SEX	DATE OF BIRTH	RELATIONSHIP TO BLUE SHIELD SUBSCRIBER	PRIOR CARRIER INFORMATION (ITEMIZE DATES OF SERVICES AND AMOUNTS APPLIED)	
				MONTH/YEAR SERVICE	AMOUNT APPLIED TO DEDUCTIBLE

PLEASE ATTACH PHOTOCOPIES OF ALL DOCUMENTS FROM PREVIOUS CARRIER FOR VERIFICATION OF APPLIED DEDUCTIBLES.

X

LIST BELOW ALL DEPENDENTS ELIGIBLE FOR COVERAGE (If more space is required use additional sheet)

RELATIONSHIP TO YOU	SEX	FIRST NAME	MI	LAST NAME	OTHER COVERAGE	FULL TIME STUDENT	DATE OF BIRTH Mo.	Day	Yea
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			
					YES NO	YES NO			

CREDIT FOR PRIOR DEDUCTIBLE, CONTINUED

PATIENT'S FULL NAME	SEX	DATE OF BIRTH	RELATIONSHIP TO BLUE SHIELD SUBSCRIBER	PRIOR CARRIER INFORMATION (ITEMIZE DATES OF SERVICES AND AMOUNTS APPLIED)	
				MONTH/YEAR SERVICE	AMOUNT APPLIED TO DEDUCTIBLE

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