Employer Notification of Qualifying Event Under Cal-COBRA (SB 719)

For Employers with 2 to 19 Eligible Employees
(2 to 19 Employees on Payroll)

Employer: Complete and return to Blue Shield of California each time a covered employee has a qualifying event which causes them to be eligible for continuation coverage under the California Continuation Benefits Replacement Act (Cal-COBRA, California Senate Bill 719).

Return within 30 days of the qualifying event to:

Blue Shield of California
Cal-COBRA
PO Box 629009
El Dorado Hills, CA 95762-9009

Please Print

Employer Name____

Group/Section Number____

Employer Phone_______________________ Employer Fax___________________

Qualified Beneficiary Name ___________________________________
(Member Eligible for Cal-COBRA)

Qualified Beneficiary Current Address___________________________

SSN___________________________Date of Qualifying Event_________________

Last Day Worked _______________________

Qualifying Event (Check One)

______Termination, resignation or reduction in employee hours

______Disqualification of dependent child under the plan

Name_________________________________SSN__________________

______Divorce or legal separation of the covered employee

Name_________________________________SSN__________________

______Death of the covered employee (for dependent qualification)

______Entitlement to Medicare Benefits by covered employee (for dependent qualification)

______Termination or reduction of hours due to disability

Employer Signature ____________________________________ **Date**___________

Blue Shield of California Cal-COBRA **(800) 228-9476 Fax (916) 350-7480**