

- Please print firmly
- Do not write in shaded area
- Please return completed form to your employer

**EMPLOYEE INFORMATION**

LAST NAME				FIRST NAME				MI	
SOCIAL SECURITY NUMBER				GROUP/BILLING UNIT NUMBER				NUMBER OF YEARS EMPLOYED AT THIS GROUP PRIOR TO COBRA QUALIFYING EVENT	

**QUALIFYING EVENT (Check One)**

- |                                                                              |                                                                               |                                                                              |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input type="checkbox"/> Death of covered employee                           | <input type="checkbox"/> Entitlement to Medicare benefits by covered employee | <input type="checkbox"/> Retiree under Chapter 11                            |
| <input type="checkbox"/> Termination or reduction in covered employee hours  | <input type="checkbox"/> Disqualification of Dependent child under the plan   | <input type="checkbox"/> Termination or reduction of hours due to disability |
| <input type="checkbox"/> Divorce or legal separation of the covered employee |                                                                               |                                                                              |

Is this application for First time COBRA coverage or an Extension of existing coverage?  1<sup>st</sup> Time  Extension

DATE OF QUALIFYING EVENT \_\_\_\_\_ SIGNATURE OF EMPLOYER \_\_\_\_\_ DATE \_\_\_\_\_

**QUALIFYING SUBSCRIBER INFORMATION**

SOCIAL SECURITY NO.				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		SEX		MARRIED		DOES QUALIFYING SUBSCRIBER HAVE OTHER HEALTH COVERAGE?		YES		NO		
MO	DAY	YR	M	F	YES	NO	YES	NO	X	R		

**X** \_\_\_\_\_  
SIGNATURE OF QUALIFYING SUBSCRIBER DATE \_\_\_\_\_

**YOU MUST SELECT A PERSONAL PHYSICIAN**

from the list of Personal Physicians in your Blue Shield Physician Directory for yourself and each of your eligible dependents. You may choose the same or a different Blue Shield Personal Physician for each family member.

Relation	First Name	Personal Physician Name	Physician Number	City Where The Physician Is Located
SELF				

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

Relationship To You	Sex	First Name	MI	Last Name	Date of Birth	Mo.	Day	Year
PERSONAL PHYSICIAN NAME				PERSONAL PHYSICIAN NO.		CITY PHYSICIAN LOCATED IN		
Relationship To You	Sex	First Name	MI	Last Name	Date of Birth	Mo.	Day	Year
PERSONAL PHYSICIAN NAME				PERSONAL PHYSICIAN NO.		CITY PHYSICIAN LOCATED IN		
Relationship To You	Sex	First Name	MI	Last Name	Date of Birth	Mo.	Day	Year
PERSONAL PHYSICIAN NAME				PERSONAL PHYSICIAN NO.		CITY PHYSICIAN LOCATED IN		
Relationship To You	Sex	First Name	MI	Last Name	Date of Birth	Mo.	Day	Year
PERSONAL PHYSICIAN NAME				PERSONAL PHYSICIAN NO.		CITY PHYSICIAN LOCATED IN		