



**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)**

- |  |   |  |
|--|---|--|
| <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 |   |  |

**DATE OF QUALIFYING EVENT**      Month   Day   Year

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      SIGNATURE OF EMPLOYER      DATE

**QUALIFYING SUBSCRIBER INFORMATION**

SOCIAL SECURITY NO.	<b>DO NOT WRITE IN SHADED AREAS</b>			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			<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**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 deductions.

**This section is not required if you are applying for an extension.**

SUBSCRIBER NAME	BLUE SHIELD GROUP NO.	I.D./SOCIAL SECURITY NO.	EFFECTIVE DATE OF COVERAGE
NAME OF GROUP		PLEASE LIST EACH FAMILY MEMBER SEPARATELY <b>(FORM CONTINUES ON REVERSE SIDE)</b>	

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**      SIGNATURE OF QUALIFYING SUBSCRIBER      DATE

