CaliforniaChoice®
Your Health. Your Choice.®

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(800) 558-8003 • www.calchoice.com

COBRA Enrollment Application

Application must be COMPLETED in FULL, SIGNED and DATED for processing.

EMPLOYER: Complete section below - then provide form to COBRA eligibles for completion

Qualifying/Triggering Event

☐ Involuntary Termination ☐ Death of Employee ☐ Divorce/Legal Separation from Employee
☐ Resignation ☐ Medicare Entitlement
☐ Reduction of Hours ☐ Child No Longer Eligible

Date of Qualifying/Triggering Event (MM/DD/YYYY)

Date of Election (MM/DD/YYYY)†

Employee Last Name

Employee Social Security #

Employee First Name

Group #

† Date of Election is the date of postmark, fax, or other delivery means when the applicant returned this form.

COBRA ENROLLEE: Complete all sections below

Applicant Last Name

Applicant Social Security #

Applicant First Name

Relationship to Employee
☐ Self ☐ Spouse ☐ Child(ren) ☐ Domestic Partner

Your Address (required) **Apt. #** **City**

State **ZIP Code** **County** **Daytime Phone #** **E-mail Address**

Mailing Address ***(if different from above)*** **Apt. #** **City**

State **ZIP Code** **County**

Please list only those individuals to be enrolled

	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
Enrolling For?	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	☐ Medical ☐ Vision ☐ Dental ☐ Chiro
Last Name					
First Name					
Relationship to Employee		☐ Spouse ☐ Domestic Partner			
Social Security #					
Gender	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Date of Birth (MM/DD/YYYY)					

Please attach another sheet if you need more space to list dependents. COBRA coverage is only available to those persons who were enrolled on the policy the day before the Qualifying/Triggering Event occurred. Newly eligible dependents must be added within 30 days of becoming eligible (date of birth/adoption or date of marriage/domestic partnership). Dental, Chiro and Vision are only available to you if the employer group offers them. If you check off a column that the group does not offer, or that you were not enrolled on prior to your Qualifying/Triggering Event date, you will not be enrolled on that coverage under COBRA.

Please read and sign below

I hereby apply for continuation of my coverage and those eligible members of my family listed above in the group health plan provided through CaliforniaChoice for which I was covered on the date prior to the Qualifying/Triggering Event. I understand that I must immediately notify the employer from whom I obtained continuation of coverage upon: becoming covered under any other group health plan; becoming eligible for Medicare benefits; or if, as a former spouse of the subscriber, I remarry and become covered under the new spouse's group health plan. I understand that it is my responsibility to report to CaliforniaChoice any change in the eligibility of my dependents; that the benefits and services of this plan are coordinated with those provided by any group hospital or medical benefit or service plan; and that any controversy between any member and health plan (including its agents, staff physicians, employees and providers) involving a claim in tort, contract or otherwise, is subject to binding arbitration.

Applicant Signature **Print Name** **Date (MM/DD/YYYY)**

PLEASE RETURN COMPLETED FORM TO YOUR PREVIOUS EMPLOYER

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CC 0600 9/2019 Eff. 1/1/2020
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