

COBRA Enrollment Application

721 South Parker, Suite 200, Orange, CA 92868 (800) 558-8003 • www.calchoice.com

Application must be COMPLETED in FILL SIGNED and DATED for processing

EMPLOVER: Comr	olete section held	ow - then provide for	orm to CORRA eli	aibles for complet	ion
Qualifying/Triggering Ev		ow - then provide it		Date of Qualifying/Triggeri	
☐ Involuntary Termination ☐ Death of Employee ☐ Divorce/Legal			ĺ	Date of Qualitying/Triggeri	IIg Event (MIM/DD/1111)
☐ Resignation	☐ Medicare Entitleme	Sonaration from	l		
Reduction of Hours Child No Longer Eli		Employee		Date of Election (MM/DD/YYYY)	
Employee Last Name				Employee Social Sec	urity #
Employee First Name				G	roup #
				Γ	
Data of Florian is the data of	of postmark, fay, or other delive	on means when the applicant ret	urned this form	L	
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 Secu	urity #
Applicant First Name				Relationship to Empl	•
				Self Spouse	☐ Child(ren)
Your Address (required)	<u>, , , , , , , , , , , , , , , , , , , </u>	<u> </u>	Apt. #	☐ Domestic Partner City	
(
State ZIP Code	County	Doutim		L E-mail Address	
State ZIP Code	County	Dayuiii	e Phone #	E-mail Address	
Mailing Address (if diffe	rent from above)		Apt. #	City	
State ZIP Code	County				
1 11					
1 11			Ple	ase list <u>only</u> those individ	uals to be enrolled ▼
	Employee	Spouse/Domestic Partner	Ple		uals to be enrolled ▼ Child 3
	Employee	Spouse/Domestic Partner	Child 1	Child 2	Child 3
Enrolling For?	Employee Medical Vision Dental Chiro	Spouse/Domestic Partner Medical Vision Dental Chiro		Child 2	
	☐ Medical ☐ Vision	☐ Medical ☐ Vision	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 ☐ Medical ☐ Vision
Enrolling For? Last Name	☐ Medical ☐ Vision	☐ Medical ☐ Vision	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 ☐ Medical ☐ Vision
	☐ Medical ☐ Vision	☐ Medical ☐ Vision	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 ☐ Medical ☐ Vision
Last Name First Name	☐ Medical ☐ Vision	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 ☐ Medical ☐ Vision
Last Name First Name Relationship to Employee	☐ Medical ☐ Vision	Medical Vision Dental Chiro	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 ☐ Medical ☐ Vision
Last Name First Name	☐ Medical ☐ Vision	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 Medical Vision Dental Chiro
Last Name First Name Relationship to Employee	☐ Medical ☐ Vision	☐ Medical ☐ Vision ☐ Dental ☐ Chiro	Child 1 ☐ Medical ☐ Vision	Child 2	Child 3 ☐ Medical ☐ Vision
Last Name First Name Relationship to Employee Social Security # Gender Date of Birth	Medical Vision Dental Chiro	Medical Vision Dental Chiro Spouse Domestic Partner	Child 1 Medical Vision Dental Chiro	Child 2 Medical Vision Dental Chiro	Child 3 Medical Vision Dental Chiro
Last Name First Name Relationship to Employee Social Security # Gender Date of Birth (MM/DD/YYYY)	Medical Vision Dental Chiro Male Female	Medical Vision Dental Chiro Spouse Domestic Partner Male Female	Child 1 Medical Vision Dental Chiro Male Female	Child 2 Medical Vision Dental Chiro Male Female	Child 3 Medical Vision Dental Chiro Male Female
Last Name First Name Relationship to Employee Social Security # Gender Date of Birth (MM/DD/YYYY) Please attach another shee	Medical Vision Dental Chiro Male Female	Medical Vision Dental Chiro Spouse Domestic Partner	Child 1 Medical Vision Dental Chiro Male Female Coverage is only available	Child 2 Medical Vision Dental Chiro Male Female	Child 3 Medical Vision Dental Chiro Male Female
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PLEASE RETURN COMPLETED FORM TO YOUR PREVIOUS EMPLOYER

