

# 2-50 Small Group Employee Information Change Form



**Note: Credit for deletions will appear on a subsequent billing. (Do not send this form with payment.)**

Group name	Group no.
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## USE THIS FORM FOR:

- Notification of terminations of employees/dependents
- Address changes
- COBRA/Cal-COBRA notifications
  - COBRA is for groups of 20 or more
  - Cal-COBRA applies to groups with 2 to 19 full-time and part-time employees

Name of person completing form	Signature <b>X</b>	Date signed	Due date	Phone no. (      )
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## SECTION 1: TERMINATING EMPLOYEES

Please submit deletions as they occur. **RETROACTIVE CANCELLATIONS ARE NOT ALLOWED.**

Note: If the employee is Federal COBRA-eligible, PLEASE be sure the employee has elected COBRA before checking YES to "Start Federal COBRA." Please refer to Federal COBRA Guidelines in regard to Federal COBRA eligibility.

SSN or ID no.	Employee name (Last name, first name)	Date of birth	Termination date (Last day worked)	Offer Cal-COBRA?	Cal-COBRA or Federal COBRA Qualifying Event	Start Federal COBRA?
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION 2: ACTIVE EMPLOYEES DECLINING COVERAGE FOR SELF OR DEPENDENT(S)

Employees cancelling coverage for themselves or their dependent(s) **MUST COMPLETE** Sections 2 and 4 of the Employee Application or the Employee Waiver Form in compliance with California State Law AB 1672. Please attach the completed application/Waiver Form declining coverage to this form.

Note: Federal COBRA-eligible dependent **MUST COMPLETE** an application to enroll on Federal COBRA.

SSN or ID no.	Employee name (Last name, first name)	Date of birth	Check one	Coverage to be deleted	Is dependent electing Federal COBRA?	Reason for cancellation	Cancellation effective date
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Employee <input type="checkbox"/> Dependent	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## SECTION 3: EMPLOYEE/GROUP CHANGE OF ADDRESS

This section should be used for groups and/or member address changes.

Note: The Group **MAY** experience a rate change upon the address change of an employee. Employees moving out of state are not eligible for HMO or EPO plans.

### A. EMPLOYEE CHANGE OF ADDRESS

SSN or ID no.	Employee name (Last name, first name)	Date of Birth	New street address	City	State	ZIP code	Phone no.

### B. GROUP CHANGE OF ADDRESS

New billing address	New local address	City	State	ZIP code	Phone no.

**To expedite processing, you may:**

**Fax form to: 805-499-0842 (If faxed, please retain original.) OR**  
**Mail form to: Anthem Blue Cross P.O. Box 9062 Oxnard, CA 93031-9602**

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