

KAISER PERMANENTE CHOICE SOLUTION

A CHOICE Administrators® Program

NOTICE
COBRA CONTINUATION: FAMILY MEMBERS WHO WERE NOT COVERED UNDER YOUR PREVIOUS GROUP PLAN MAY NOT BE ADDED UNTIL OPEN ENROLLMENT

Cal-COBRA **ENROLLMENT APPLICATION**

EMPLOYER: COMPLETE TOP SECTION, THEN PROVIDE FORM TO COBRA ELIGIBLES FOR COMPLETION.

QUALIFYING EVENT:

- Termination Of Employment
- Reduction Of Hours
- Divorce/Legal Separation From Employee
- Child No Longer Eligible
- Medicare Entitlement*
- Death Of Employee

Date Of Qualifying Event:

Date Of Election:[†]

Employee Last Name

Employee Social Security Number

Employee First Name

Group #

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

* Employee is entitled to Medicare upon the effective date of enrollment in either Part A or Part B, whichever is earlier.

COBRA ENROLLEE: COMPLETE ALL SECTIONS BELOW

Applicant Last Name

Applicant Social Security Number

Applicant First Name

RELATIONSHIP TO EMPLOYEE:

- SELF
- SPOUSE
- DOMESTIC PARTNER
- CHILD(REN)
- GRANDCHILD(REN)*

PLEASE LIST ONLY THOSE INDIVIDUALS TO BE ENROLLED: (Those added below for medical will be automatically enrolled for dental)

	Last Name	First Name	Sex	Social Security Number	Birth Date (Mo/Day/Year)	Full Time Student?	✓ for Medical	✓ for Dental
YOU			<input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /			
SPOUSE			<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /			
CHILDREN			<input type="checkbox"/> Child <input type="checkbox"/> Grandchild* <input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Child <input type="checkbox"/> Grandchild* <input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Child <input type="checkbox"/> Grandchild* <input type="checkbox"/> Male <input type="checkbox"/> Female	— —	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No		

*Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

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 Event occurred. Newly eligible dependents must be added within 30 days of becoming eligible (date of birth/adoption or date of marriage). Dental is only available to you if the employer group offers them.

YOUR ADDRESS _____

CITY _____ STATE _____ ZIP _____ DAYTIME PHONE NUMBER (_____) _____

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 Kaiser Permanente Choice Solution for which I was covered on the date prior to the Qualifying Event. I understand that I must immediately notify the employer from whom I obtained continuation of coverage upon: becoming covered under any other group healthplan; 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 healthplan. I understand that it is my responsibility to report to CHOICE Administrators 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.

PLEASE RETURN COMPLETED FORM TO HEALTH PLAN ADMINISTRATOR

APPLICANT SIGNATURE _____

DATE _____

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Cal-COBRA

DEPENDENT QUALIFYING EVENT

NOTIFICATION

INSTRUCTIONS: This form must be completed in the event that a dependent of an employee loses health coverage due to one of the following Qualifying Events:

- A divorce or legal separation
- Medicare entitlement of the employee
- Death of the employee
- Loss of dependent child status

You must complete this form and mail it to CHOICE Administrators within 60 days of one of the events listed above.

1 PLEASE LIST NAME/ADDRESS OF DEPENDENT ELIGIBLE FOR CONTINUATION COVERAGE

Dependent Last Name												Dependent Social Security Number					
Dependent First Name												Middle Initial					
Dependent Address																	
City												State			Zip		

Employee Last Name												Employee Social Security Number					
Employee First Name												Group #					

2 QUALIFYING EVENT INFORMATION

One of the following Qualifying Events has occurred that could entitle a dependent, spouse or ex-spouse of an employee to continuation of health benefits (check one):

- Divorce or legal separation between employee and spouse
- Dependent child has lost coverage due to child ceasing to qualify as a dependent under the plan
- Death of employee
- Medicare entitlement of employee

Today's Date	Date Of Qualifying Event*	Was Covered Dependent Disabled At Time Of The Qualifying Event?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**Current coverage will be terminated on the last day of the month in which qualifying event occurred if this form is received within 60 days of the Qualifying Event.*

3 QUALIFYING BENEFICIARY INFORMATION

Name of dependent(s) affected by the Qualifying Event (lost health coverage) and their relationship to the employee

NAME	DATE OF BIRTH	SEX	RELATIONSHIP
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*
	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild*

*Grandchildren may be covered if the parent is enrolled. Please advise name of enrolled parent:

4 CERTIFICATION

I understand that notification must be made to CHOICE Administrators within 60 days of the Qualifying Event. I hereby certify that the information above is true and correct to the best of my knowledge.

APPLICANT SIGNATURE

DATE

Send completed form to: **CHOICE Administrators**
721 South Parker, Suite 200, Orange, CA 92868