1-50 Small Group Information Change Form

Anthem BlueCross

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

Group name	Group no.

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	Email address	Date signed	Phone no.
	X			( )

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?
				☐ Yes ☐ No		☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No

Employees canceling coverage for themselves or their dependent(s) MUST COMPLETE sections A and F of the *Employee Application* or the *Employee Waiver Form*. 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
			☐ Employee ☐ Dependent	☐ Medical ☐ Dental ☐ Life ☐ Vision	☐ Yes ☐ No		
			☐ Employee ☐ Dependent	☐ Medical ☐ Dental ☐ Life ☐ Vision	☐ Yes ☐ No		
			☐ Employee ☐ Dependent	☐ Medical ☐ Dental ☐ Life ☐ Vision	☐ Yes ☐ No		

SECTION 2: EMPLOYEE/GROUP CHANGE OF ADDRESS

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

Note: Employees moving out of state are not eligible for HMO 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.

* Anthem Blue Cross is required by the Internal Revenue Service to collect this information.

To expedite processing, you may:

Fax form to: 1-855-750-2227 *(If faxed, please retain original.)* ***OR***

Mail form to: Anthem Blue Cross, P.O. Box 9062, Oxnard, CA 93031-9602

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