

**Employer Notification of Qualifying Event Under  
Cal-COBRA (SB 719)**

For Employers with 2 to 19 Eligible Employees  
(2 to 19 Employees on Payroll)

Employer: Complete and return to Blue Shield of California each time a covered employee has a qualifying event which causes them to be eligible for continuation coverage under the California Continuation Benefits Replacement Act (Cal-COBRA, California Senate Bill 719).

**Return within 30 days of the qualifying event to:**

Blue Shield of California  
Cal-COBRA  
PO Box 629009  
El Dorado Hills, CA 95762-9009

Please Print

Employer Name \_\_\_\_\_

Group/Section Number \_\_\_\_\_

Employer Phone \_\_\_\_\_ Employer Fax \_\_\_\_\_

Qualified Beneficiary Name \_\_\_\_\_  
(Member Eligible for Cal-COBRA)

Qualified Beneficiary Current Address \_\_\_\_\_

SSN \_\_\_\_\_ Date of Qualifying Event \_\_\_\_\_

Last Day Worked \_\_\_\_\_

**Qualifying Event (Check One)**

\_\_\_\_ Termination, resignation or reduction in employee hours

\_\_\_\_ Disqualification of dependent child under the plan

Name \_\_\_\_\_ SSN \_\_\_\_\_

\_\_\_\_ Divorce or legal separation of the covered employee

Name \_\_\_\_\_ SSN \_\_\_\_\_

\_\_\_\_ Death of the covered employee (for dependent qualification)

\_\_\_\_ Entitlement to Medicare Benefits by covered employee (for dependent qualification)

\_\_\_\_ Termination or reduction of hours due to disability

**Employer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Blue Shield of California Cal-COBRA (800) 228-9476 Fax (916) 350-7480

**Active Choice plans are underwritten by Blue Shield of California Life & Health Insurance Company.**