# ANTHEM BLUE CROSS AND BLUE SHIELD
# COBRA PARTICIPANT REGISTRATION FORM

GROUP NAME: ______________________ ☐ Active Participant ☐ Member Needs to be Notified

GROUP NUMBER: C ______________________ ☐ Pending (participant was notified, but awaiting election)

**DIVISION(S):**

☐ ______________________

☐ ______________________

**QUALIFIED APPLICANT INFORMATION:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| LAST NAME | | | FIRST NAME | | | | |
| ADDRESS | | CITY | | STATE | | ZIP | |
| SOCIAL SECURITY # | - - | | GENDER | ☐ M ☐ F | DATE OF BIRTH | | |
| RELATIONSHIP | ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD | SEVERENCE END DATE IF APPLICABLE | | | | | |
| QUALIFYING EVENT | ☐ RETIREE ☐ DEATH OF EMPLOYEE ☐ DIVORCE<br>☐ LAYOFF ☐ LEAVE OF ABSENCE ☐ MEDICAL LEAVE<br>☐ STRIKE ☐ MILITARY LEAVE ☐ REDUCED HOURS<br>☐ TERMINATION ☐ LOSS OF DEPENDENT STATUS<br>☐ ENTITLEMENT TO MEDICARE, DATE _____ | | | QUALIFYING EVENT DATE | | | |
| | | | | PAID THROUGH DATE | | | |

**EMPLOYEE INFORMATION (FOR USE ONLY IF DEPENDENT IS QUALIFIED APPLICANT):**

| | | | | | |
|---|---|---|---|---|---|
| LAST NAME | | FIRST NAME | | SSN | - - |

**COVERAGE INFORMATION (SELECT CURRENT COVERAGES):**

| | | | |
|---|---|---|---|
| ☐ MEDICAL/RX | ☐ SINGLE ☐ EMPLOYEE + SPOUSE<br>☐ EMPLOYEE + CHILD ☐ FAMILY | ☐ PREMIUM (BUY-UP PLAN)<br>☐ STANDARD (CORE)<br>☐ HRA/HSA | ☐ ANTHEM PRODUCT<br>☐ NON-ANTHEM PRODUCT |
| ☐ DENTAL | ☐ SINGLE ☐ EMPLOYEE + SPOUSE<br>☐ EMPLOYEE + CHILD ☐ FAMILY | ☐ PREMIUM (BUY-UP PLAN)<br>☐ STANDARD (CORE)<br>☐ HRA/HSA | ☐ ANTHEM PRODUCT<br>☐ NON-ANTHEM PRODUCT |
| ☐ VISION | ☐ SINGLE ☐ EMPLOYEE + SPOUSE<br>☐ EMPLOYEE + CHILD ☐ FAMILY | ☐ PREMIUM (BUY-UP PLAN)<br>☐ STANDARD (CORE)<br>☐ HRA/HSA | ☐ ANTHEM PRODUCT<br>☐ NON-ANTHEM PRODUCT |

**PRESENTLY COVERED DEPENDENTS(*This information must be completed in order to give the applicant the correct coverage*)::**

| LAST NAME | FIRST NAME | SS # | BIRTH DATE | GENDER | RELATIONSHIP |
|---|---|---|---|---|---|
| | | - - | | ☐ M ☐ F | ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD |
| | | - - | | ☐ M ☐ F | ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD |
| | | - - | | ☐ M ☐ F | ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD |
| | | - - | | ☐ M ☐ F | ☐ EMPLOYEE ☐ SPOUSE ☐ CHILD |
| | | - - | | M F | ☐ EMPLOYEE ☐ SPOUSE CHILD |
| | | - - | | M F | EMPLOYEE SPOUSE CHILD |

COMMENTS:

COMPLETED BY: DATE COMPLETED:

******* FAX COMPLETED DOCUMENT TO 614-880-3480 OR EMAIL TO** *****

Anthem Blue Cross & Blue Shield
COBRA & Billing Administration
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