1-100 Small Group Information Change Form

Anthem BlueCross

Use this form for:

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

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

Section 1: Employer information

Employer name		Group/Case no.
Name of person completing form	Email address	Phone no.
Signature **X**		Date signed

Section 2: 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.

Social Security no.* 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
				☐ 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.

Social Security no.* 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/Disability ☐ Vision	☐ Yes ☐ No		
			☐ Employee ☐ Dependent	☐ Medical ☐ Dental ☐ Life/Disability ☐ Vision	☐ Yes ☐ No		
			☐ Employee ☐ Dependent	☐ Medical ☐ Dental ☐ Life/Disability ☐ Vision	☐ Yes ☐ No		
			☐ Employee ☐ Dependent	☐ Medical ☐ Dental ☐ Life/Disability ☐ Vision	☐ Yes ☐ No		

* Anthem Blue Cross is required by the Internal Revenue Service and the Centers for Medicare and Medicaid Services (CMS) to collect this information.

Group/Case no.

Section 3: Employee/Employer change of address

This section should be used for employer and/or member address changes.
Note: Employees moving out of state are not eligible for HMO plans.

A. Employee change of address

Social Security no.* or ID no.	Employee name (Last name, first name)	Date of birth	New street address	City	State	ZIP code	Phone no.

B. Employer change of address

New **billing** street address	City	State	ZIP code
County	Phone no.	Fax no.	
New **local** street address	City	State	ZIP code
County	Phone no.	Fax no.	

New **email** address: _____

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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

Please send to Wayco by email or fax
john@wayco.com or fax 951.699.8002