California Group Health Coverage

Employer Notice of Occurrence of Qualifying Event for the Right to Continuation Coverage under CalCOBRA Consumer Markets 2-19 size groups

Please Print

Name of Employee			Name of Employer		
Address			Address		
City	State	ZIP Code	City	State	ZIP Code
Employee's ID Number	Employee's telephone number		Employee's e-mail address		
Group Control Number	Today's Date		Date of Qualilfying Event/Termination of Coverage		

Continuation of Group Health Coverage is available to the above employee and/or dependent(s).
Loss of coverage is due to the following (check one):

- ☐ **1**. Termination of employment (other than for gross misconduct), loss of eligibility due to reduction in hours.
- ☐ **2**. The employee's death.
- ☐ **3.** Divorce or legal separation.
- ☐ **4.** Loss of dependent status.
- ☐ **5.** Loss of dependent coverage when employee became entitled to Medicare benefits.

The group health coverage under which the above individual(s) have been covered will cease because of the reason and on the Date of the Qualifying Event indicated above. An Election Form to Continue Coverage will be sent by Aetna to the qualified beneficiary. If the qualified beneficiary elects continuation and pays the premium, elected benefits will be reactivated without lapse in coverage.

A. Within 31 days after the above event or the termination of coverage, whichever is later, the employer must complete and return this form to:

Aetna
Employer Services CalCOBRA
1385 E. Shaw Avenue
Fresno, CA 93710

Telephone: 1-800-343-6101

B. Within 14 days of receipt, Aetna will send an Election Form and premium information directly to the qualified beneficiary.

C. If the qualified beneficiary wishes continued coverage, s/he must notify Aetna in writing within 60 days of the later of:
- The qualifying event
- The date the employee is given notice.

D. The first premium payment must be received by Aetna within 45 days of the date the qualified beneficiary provides written notice of election.

Name and Address of all Other Beneficiaries (Covered Spouse and Covered Dependent Children)

Name	Address	City	State	ZIP Code
1.				
2.				
3.				