1–100 Small Group Information Change Form

Anthem

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.[1] 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.[1] 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		

1 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.[1] 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 **principal business**[2] address	City	State	ZIP code
County	Phone no.	Fax no.	

New **email** address: _____

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2 The principal business address means the principal business address registered with the State or, if a principal business address is not registered with the State, or is registered solely for purposes of service of process and is not a substantial worksite for the policyholder's business, the business address within the State where the greatest number of employees of such policyholder works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area, the principal business address for purposes of the network plan is the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the rating area for purposes of the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

To expedite processing, you may:

Reset Form Save and Print

- Process online changes through EmployerAccess Employer Portal
- Fax form to: 1-855-750-2227 (If faxed, please retain original.)
- Mail form to: Anthem Blue Cross
  P.O. Box 9062
  Oxnard, CA 93031-9062