



Date:

Group No.:
Certificate No.:
Dependent's Name:
Dependent's Deletion Date:
Birth Date:
Member Code:

Dear Member:

According to our records, your child will soon be ineligible for coverage as your dependent. Unless you notify us that he or she may be eligible for continued coverage, his or her coverage under your group policy will terminate on the Dependent Deletion Date as shown above or earlier if it is determined that this dependent is ineligible. If this occurs, he or she may be eligible for continued coverage under COBRA or under an individual conversion policy. Please contact your employer/plan administrator for additional details regarding these options.

Please let us know the status of your dependent by completing the appropriate area below: (Please check all applicable items.)

\_\_\_ Your records are incorrect. This child's birth date is \_\_\_\_\_.

\_\_\_ This child is unmarried and qualified as a dependent for federal income tax purposes.

\_\_\_ My contract specifies continued eligibility as a dependent to a stated age if a full-time student, qualified as a dependent for federal income tax purposes, and unmarried. Dependent is currently enrolled in \_\_\_ units.

Name of School: \_\_\_\_\_. My signature below certifies that the child meets these requirements.

\_\_\_ My child is incapable of self-sustaining employment by reason of physical handicap or mental retardation. My child \_\_\_ (is) or \_\_\_ (is not) covered at this time under Medicare disability program. Please attach a letter from the child's physician explaining the diagnosis, providing relevant ICD9 Codes, extent of disability and prognosis.

\_\_\_ Dependent is no longer eligible for coverage. Please remove as of the above referenced deletion date.

\_\_\_ Dependent is no longer eligible for coverage as of \_\_\_\_\_ (please provide deletion date if dependent is to be removed sooner than the date noted above).

Please return this form to the address below within 15 days to avoid your dependent's loss of coverage.

If you have any questions regarding the above, please contact your employer or Nicole McWilliams at 818-234-2085.

Subscriber's Signature

Date

BLUE CROSS OF CALIFORNIA
P.O. BOX 629
WOODLAND HILLS, CA 91365