Blue Cross of California

Mailing Address:

P.O. Box 629
Woodland Hills, CA 92365

Group No:
Certificate No:
Dependent's Name:
Dependent Deletion Date:
Birthdate:
Member CD:

Dear Member:

According to our records, your child will be 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 the first day of the month following his or her birthdate. If this occurs, he or she may be eligible for continued coverage under COBRA or under an individual Conversation 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 are below:
(Please check any applicable item.)

☐ Blue Cross records are incorrect. This Child's birthdate is_____

☐ This Child is unmarried and dependent upon me for at least 50% of economic support, in accordance with Internal Revenue Service (IRS) regulations.

❑ My contract specifies continued eligibility as a dependent to a stated age if a full-time student, dependent upon me for 50% of economic support, 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 and mental retardation, My Child_____(is) or _____ (is not) covered at this time under Medicare disability program. If your child is not covered by Medicare, please attached a letter from the Child's physician explaining the diagnosis, extent of disability and prognosis.

☐ Dependent is no longer eligible for coverage. Please delete.

This form must be returned to the above address within 15 days to avoid the dependent loss of coverage for the above child.

_____ _____

Subscriber's Signature Date