Small Group Business
COBRA/Cal-COBRA Questionnaire

(For use in California only)

This form must be completed when replacing another group plan.

Does your group currently qualify for (choose one): ☐ COBRA ☐ Cal-COBRA

I. COBRA/Cal-COBRA Continuees – Complete for each employee currently on COBRA or Cal-COBRA

Name	Date of Birth	Social Security Number	Date of Qualifying Event	Qualifying Event	
1.					☐ COBRA ☐ Cal-COBRA
2.					☐ COBRA ☐ Cal-COBRA
3.					☐ COBRA ☐ Cal-COBRA
4.					☐ COBRA ☐ Cal-COBRA

II. Terminated Employees – Complete for each employee terminated in the last 90 (COBRA) or 60 days (Cal-COBRA)

1. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No		

2. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No		

3. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No		

4. Name	Date of Termination	Social Security Number
To the best of your knowledge, will this employee/dependent(s) exercise their COBRA/Cal-COBRA Option? ☐ Yes ☐ No If answered "Yes" to the above question, is the employee/dependent currently disabled? ☐ Yes ☐ No		

III. Misrepresentation

Attention California Residents: **For your protection, California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Employer Signature	Title	Date
Company Name		