

COBRA ELECTION FORM

PacifiCare ID # _____

Important: Please complete all sections. This form cannot be processed if information is incomplete.

When appropriate, attach a completed PacifiCare Enrollment Application to this Election Form

Employer Name	Group Number
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COBRA Information (To be completed by employer)

Member/Enrollee Last Name	First	M.I.
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Is the member/enrollee a current PacifiCare member/enrollee?

- Yes Please enter the PacifiCare ID Number in the box in the upper right of this form and complete Sections A and B of this form.
- No Please complete Section A only of this form and attach a completed PacifiCare enrollment form.
(If this new enrollment is not occurring during open enrollment, please attach details of the applicant's eligibility for COBRA enrollment.)

SECTION A – Qualifying Event (Please specify)

- Termination or reduction in hours of employment
- Loss of coverage due to employee Medicare entitlement
- Death of employee
- Dependent ceasing to qualify under the plan
- Divorce or legal separation
- Employer bankruptcy under Title II

Qualifying Event Date	Last Date of Coverage by Employer	COBRA Start Date	COBRA End Date
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SECTION B – List of Continuing PacifiCare Members/Enrollees only

Please complete for continuing members (beneficiaries) who will be continuing coverage. If applicable, include employee.

						HMO/POS ONLY
1	Self	Last Name	Social Security Number	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State ZIP	Medical Group Name
2	Spouse	Last Name	Social Security Number	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State ZIP	Medical Group Name
3	Relationship	Last Name	Social Security Number	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State ZIP	Medical Group Name
4	Relationship	Last Name	Social Security Number	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State ZIP	Medical Group Name
5	Relationship	Last Name	Social Security Number	Street Address		Primary Care Physician Name
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State ZIP	Medical Group Name

Benefit Coordination/Other Insurance Carrier Information

- Does anyone listed have other health insurance? Yes No If yes, complete section below.
- Is anyone listed permanently disabled? Yes No Name _____ Date disability began _____ M - D - Y
- Is anyone listed eligible for Medicare? Yes No Name _____ Medicare ID# _____

NAME	INSURANCE COMPANY NAME	POLICY NO. & EFFECTIVE DATE	OTHER EMPLOYER NAME & ADDRESS

Member/Enrollee Signature	Date	Employer Signature	Date
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PacifiCare SignatureValueSM (HMO) and PacifiCare SignaturePOSSM:
 P.O. Box 6006, MS CY24-515
 Cypress, CA 90630

PacifiCare SignatureOptionsSM (PPO)*, PacifiCare SignatureIndependenceSM (Indemnity)* and PacifiCare SignatureFreedomSM (SDHP)* :
 P.O. Box 6098
 Cypress, CA 90630

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