PacifiCare®

PacifiCare I.D. #

Cal-COBRA ELECTION FORM

Employer Name

APPLICANT INFORMATION

Applicant Name (Last) | *(First)* | *(M.I.)* | *Relationship to Employee*

Employee Name (Last) | *(First)* | *(M.I.)*

SECTION A

► ***Qualifying Event (please specify)***

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

Qualifying Event Date	*Last Date of Coverage by Employer*	*Cal-COBRA Start Date*	*Cal-COBRA End Date*

SECTION B

► ***List of continuing PacifiCare members.***

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

	Last Name	First	M.I.	Social Security Number
01				
02				
03				
04				
05				
06				

- Address of continuing member(s). *(If different from employee, specify bellow.)*

	Street Address	City	State	Zip
01				
02				
03				
04				

Applicant Signature	*Date*

Please remit all premiums due, along with this form, to: PacifiCare 5701 Katella Ave. , CY24-515, Cypress, CA 90630

PC7313
298.10843
CM-198-00733