PacifiCare®

Cal-COBRA Qualifying Event Notice Form

SECTION A – Applicant Information

Applicant Last Name	First		M.I.
Employee's or Subscriber's Name (if different from above) – Last Name	First		M.I.
Employee's Social Security Number	PacifiCare I.D. Number		
Current Home Address – Street Address	City	State	Zip
Mailing Address (if different from above)	City	State	Zip
Telephone Number ( )			

SECTION B – Qualifying Event (Please specify one of the following)

To be completed by eligible employer*:
*The completed Notice Form must be received by PacifiCare within **30 days** of the following qualifying event:*

☐ Employee termination or reduction of hours of the employee's or subscriber's employment.

To be completed by employee or subscriber:
*The completed Notice Form must be received by PacifiCare within **60 days** of the following qualifying events:*

☐ Divorce or legal separation of the covered employee from the covered employee's spouse.
☐ Death of the covered employee or subscriber.
☐ Loss of dependent status by a dependent enrolled in the group benefit plan.
☐ For dependents only, the covered employee's or subscriber's eligibility for coverage under Title XVIII of the United States Social Security Act (Medicare).

Qualifying Event Date	Last Date of Coverage by Employer
Employer Name	Employer Group Number

Signature of Employer or Enrollee	*Please print name*	*Date*

Please mail the completed Notice Form to Pacificare at:

(HMO/POS Members)
5701 Katella Avenue
MS CY24-515
Cypress, CA 90630

(PPO/Indemnity enrollees)
P.O. Box 6098
Cypress, CA 90630

* Eligible employers are those that employed 2 to 19 employees on at least 50 percent of their working days during the preceding calendar year and not eligible for federal COBRA.

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