

COBRA ELECTION FORM

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

PacifiCare ID #

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)

Insured Last Name	First	Middle Initial
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Is the insured a current PacifiCare insured?

- 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 insureds only

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

1	Self	Last Name	Social Security Number	Street Address		
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State	ZIP
2	Spouse	Last Name	Social Security Number	Street Address		
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State	ZIP
3	Relationship	Last Name	Social Security Number	Street Address		
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State	ZIP
4	Relationship	Last Name	Social Security Number	Street Address		
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State	ZIP
5	Relationship	Last Name	Social Security Number	Street Address		
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State	ZIP
6	Relationship	Last Name	Social Security Number	Street Address		
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year)	City	State	ZIP

Insured Signature	Date	Employer Signature	Date
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**P.O. Box 6098
Cypress, CA 90630**

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Underwritten by PacifiCare Life Assurance Company