

CAL-COBRA QUALIFYING EVENT NOTICE FORM

SECTION A – Applicant Information			
Applicant's 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*: <i>The completed Notice Form must be received by PacifiCare within 30 days of the following qualifying event:</i>		<input type="checkbox"/> Employee termination or reduction of hours of the employee's or subscriber's employment.	
To be completed by employee or subscriber: <i>The completed Notice Form must be received by PacifiCare within 60 days of the following qualifying events:</i>		<input type="checkbox"/> Divorce or legal separation of the covered employee from the covered employee's spouse. <input type="checkbox"/> Death of the covered employee or subscriber. <input type="checkbox"/> Loss of dependent status by a dependent enrolled in the group benefit plan. <input type="checkbox"/> 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	

* 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.

**PacifiCare SignatureValueSM (HMO),
 PacifiCare SignaturePOSSM,
 PacifiCare SignatureOptionsSM (PPO)**,
 PacifiCare SignatureIndependenceSM (Indemnity)**,
 and PacifiCare SignatureFreedomSM (SDHP)****
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