

PacifiCare ID Number
----------------------

### Employer Information

Employer Name
---------------

### Applicant Information

Applicant Last Name	First	M.I.	Relationship to Employee
Employee Last Name	First	M.I.	

### 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

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 enrollees (beneficiaries) who will be continuing coverage. If applicable, include employee.

<b>1</b>	Last Name	Street Address (If different from employee)		
	First Name	M.I.	City	State Zip
<b>2</b>	Last Name	Street Address (If different from employee)		
	First Name	M.I.	City	State Zip
<b>3</b>	Last Name	Street Address (If different from employee)		
	First Name	M.I.	City	State Zip
<b>4</b>	Last Name	Street Address (If different from employee)		
	First Name	M.I.	City	State Zip
<b>5</b>	Last Name	Street Address (If different from employee)		
	First Name	M.I.	City	State Zip
<b>6</b>	Last Name	Street Address (If different from employee)		
	First Name	M.I.	City	State Zip

Applicant Signature	Date
---------------------	------

**Please remit all premiums due, along with this form, to:**  
*(HMO/POS Members)*                      *(PPO/Indemnity Enrollees)*  
 PacifiCare                                      PacifiCare  
 5701 Katella Avenue, CY24-515              P.O. Box 6098  
 Cypress, CA 90630                              Cypress, CA 90630