PacifiCare®
Life Assurance Company

COBRA Election Form

IMPORTANT: PLEASE COMPLETE ALL SECTIONS
This form cannot be processed if information is incomplete.

P.O. Box 6098
Cypress, CA 90630

PacifiCare ID #

WHEN APPROPRIATE, ATTACH A COMPLETED PACIFICARE ENROLLMENT APPLICATION TO THIS ELECTION FORM

Employer Name	Group Number

COBRA INFORMATION (To be completed by employer)

Insured Last Name	First	M.I.

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
☐ Death of employee
☐ Divorce or legal separation
☐ Loss of coverage due to employee Medicare entitlement
☐ Dependent ceasing to qualify under the plan
☐ Employer bankruptcy under Title II

Qualifying Event Date	Last Date of Coverage by Employer	COBRA Start Date	COBRA End Date

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*