

COBRA Election Form

PacifiCare[®]
Dental & Vision Administrators

Attn: Membership Accounting LC05-232
PacifiCare Dental & Vision Administrators
Post Office Box 25187
Santa Ana, California 92704
Tel 800-228-3384
Fax 714-513-6507 or 714-513-6397

Notice of qualifying event

To advise PacifiCare Dental & Vision Administrators of an event that qualifies an employee for continuation of benefits under COBRA, this notice must be completed by the employer and signed by the employee upon the employee's election to continue benefits. The completed form should then be mailed to PacifiCare Dental & Vision Administrators, P.O. Box 66033, Anaheim, CA 92816.

On _____, 20_____, _____
(Date of qualifying event) (Name of employee)

SSN: _____, an employee of _____
(Name of employer)

Group Number _____ and a plan participant of PacifiCare Dental & Vision Administrators became eligible for continuation of coverage due to:

- | | |
|---|--|
| <input type="checkbox"/> Termination of employment | <input type="checkbox"/> Loss of coverage due to employee Medicare entitlement |
| <input type="checkbox"/> Reduction in hours resulting in loss of coverage | <input type="checkbox"/> Age limitation of a dependent being reached |
| <input type="checkbox"/> Divorce or legal separation | <input type="checkbox"/> Death of employee |

Effective date: _____ For a term of: _____ months.

Continuation is requested for: Dental Vision Both

Employee's address: _____ Spouse's name & address (If insured)

Employee's daytime phone: (____) _____ Spouse's daytime phone: (____) _____

Dependent children: List if covered (Use reverse side if necessary)

Name _____ (____) *	Name and address of other children not residing with employee or spouse. _____ _____ _____
Name _____ (____) *	
Name _____ (____) *	
Name _____ (____) *	
Name _____ (____) *	

*Enter "S" if residing with Spouse and not with Employee.

(Employer signature) (Date completed)

(Title)

I hereby request continuance of my PacifiCare Dental & Vision Administrators benefits under the provisions of COBRA. I understand that by law it is my employer's responsibility to determine my eligibility, arrange for my continued coverage, and determine the proper term of coverage to which I am entitled. My monthly payment will consist of my monthly premium plus a 2% administration fee. I understand that if I fail to pay my monthly premium, my coverage will be cancelled and will not be eligible for reinstatement.

(Employee signature) (Date)