PacifiCare®

Employer Group Reporting Form

P.O. Box 6006, MS CY24-515, Cypress, CA 90630-5028 • *Fax Numbers:* Incoming Fax: **(714) 226-5947**
Imaging Fax: **(714) 952-3829**

Please complete information below and forward to PacifiCare within 30 days from effective date.

Reinstatements: If reinstating or transferring to COBRA plan, member needs to submit a signed COBRA Election form.
Please use Change Request Form to add or delete family members, change address, phone, medical group, etc.

EMPLOYER NAME				GROUP NUMBER					TERMINATIONS	LAST DATE OF COVERAGE
EMPLOYEE NAME: LAST NAME	FIRST NAME	M.I.	PACIFICARE ID NUMBER OR SSN	HMO (H) POS (P) INDEM (I) LIFE (L)	REINSTATEMENT		TRANSFER EMPLOYER GROUP			ENTER TERMINATION REASON CODE	
					CHECK (✓) IF REINSTATEMENT	INCLUDES DEPENDENTS? YES (Y) / NO (N)	FROM GROUP NUMBER	TO GROUP NUMBER	EFFECTIVE DATE		

COMMENTS:

TERMINATION REASON CODES

01	Moving Out of Area	47	Expired COBRA Benefits
02	Deceased	LE	Left Employment
07	Other Insurance Benefits Available	DE	Death
16	Failure to Pay/Copay Premium	ER	Enrolled in Error
37	Multiple ID Numbers	48	Voluntary — No Reason Given
43	Transferred to Secure Horizons		

COMPLETED BY **DATE**