PacifiCare®

Employer Group Reporting Form

P.O. Box 6006, MS CY24-515, Cypress, CA 90630-5028 • Employer Group Reporting Fax Line: **(714) 226-5622**
General Fax Line: **(714) 226-5947**

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

COMMENTS:

TERMINATION REASON CODES

01	Moving Out of Area	43	Transferred to Secure Horizons
02	Deceased	47	Expired COBRA Benefits
07	Other Insurance Benefits Available	LE	Left Employment
16	Failure to Pay/Copay Premium	DV	Divorce
37	Multiple ID Numbers	ER	Enrolled in Error
42	Not Enough Hours	48	Voluntary — No Reason Given

COMPLETED BY (PRINT NAME):	SIGNATURE	TELEPHONE	DATE

Membership Accounting – Original Employer – Pink