Employer Group Reporting Form

PacifiCare®

Employer Name
Group Number(s)

- Please complete information below and forward to PacifiCare **within 30 days** from effective date. Mail to P.O. Box 6098, Cypress, CA 90630, or fax to 714-226-5622. General Fax Line: (714) 226-5947.
- **Reinstatements:** If reinstating or transferring to COBRA plan, Insured needs to submit a signed COBRA Election Form.
- Please use the *Change Request Form* to add or delete family members, change address, phone, etc.

Employee Information			Reinstatement		Transfer Employer Group			Terminations	
Employee Name (Last, First, Middle Initial)	PacifiCare ID # or SSN	HMO (H) PPO (P) POS (POS) Indemnity (I) Life (L) SDHP (S)	Check (✓) if Reinstatement	Includes Dependents? Y or N	From Group #	To Group #	Effective Date	Enter Termination Reason Code (see below)	Last Date of Coverage

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