



Arizona
Cobra Election Form

Type or print with ballpoint pen.
Do not write in shaded areas.
Incomplete information will delay
the enrollment process.

FOR PACIFICARE OFFICE USE ONLY
Table with 4 columns: Tier Code, Process Date, Processor, Approval

A. Employer Information TO BE COMPLETED BY EMPLOYER

Form with 5 columns: Employer Name (previous), Location, HMO Group No., Life Group No., Subgroup/Location No.
Employee's Last Date of Coverage, COBRA Start Date (MM/DD/YYYY), COBRA Expiration Date (MM/DD/YYYY)

B. Coverage Information

Qualifying Event:

- Termination of employment (18 Months)
Divorce or legal separation (36 Months)
Reduction in hours of employment (18 Months)
Loss of coverage due to employee Medicare entitlement (36 Months)
Death of Employee (366 Months)
Dependent ceasing to qualify under the plan (36 Months)

C. Employee / Dependent Information

Form with 8 columns: PacifiCare Member Number (SSN), Street Address, Apt, City, State, Zip Code, Country, Home Phone

Mailing Address (if different)

Medical coverage requested under COBRA?

- HMO, PPO, POS, INDEMNITY
Individual(s) Covered
Self, Spouse, Dependents

Dental coverage requested under COBRA?

- HMO, INDEMNITY
Individual(s) Covered
Self, Spouse, Dependents

If selecting HMO dental, list dentist's full name

List all Members that will be continuing coverage

Check here if currently a patient of chosen PCP

Table with 10 columns: Relationship, Last Name, First Name, MI, Sex, Social Security #, Birth Date (MM/DD/YYYY), Network/ Code #, If electing HMO Primary Care Physician provide Last Name, First Name, MI, and a checkmark column.

I hereby authorize any health care facility, physician or surgeon, or any other health care professional to disclose to PacifiCare of Arizona or PacifiCare Life Assurance Company, its agents or employees, all information from my medical records pertaining to any past or future examination or treatment including treatment for substance abuse and mental and emotional disorders furnished to me or my dependents who are also applying for this coverage, and to any illness, injury or condition that I or these dependents have had at any time in the past or in the future until the expiration of this authorization.

**If you elected HMO Plan and did not select primary care physician (PCP) and/or a HMO primary care dentist, PacifiCare will select one for you. You may select a new provider by contacting PacifiCare Customer Service (1-800-347-8600).

Applicant's Signature Date | Employer's Signature Date