

**CALIFORNIA**

# COBRA Election Form

Important: Please complete all sections. This form cannot be processed if information is incomplete.

UnitedHealthcare of California ID#

**When appropriate, attach a completed UnitedHealthcare of California Enrollment Application to this Election Form**

Employer Name	Group Number
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**COBRA Information (To be completed by employer)**

Member/Enrollee Last Name	First	M.I.
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**Is the member/enrollee a current UnitedHealthcare of California member/enrollee?**

- Yes Please enter the UnitedHealthcare of California ID Number in the box in the upper right of this form and complete Sections A and B of this form.
- No Please complete Section A only of this form and attach a completed UnitedHealthcare of California enrollment form.  
 (If this new enrollment is not occurring during open enrollment, please attach details of the applicant's eligibility for COBRA enrollment.)

**SECTION A - Qualifying Event (Please specify)**

- |  |   |
|--|---|
| <input type="checkbox"/> Termination or reduction in hours of employment<br><input type="checkbox"/> Death of employee<br><input type="checkbox"/> Divorce or legal separation | <input type="checkbox"/> Loss of coverage due to employee Medicare entitlement<br><input type="checkbox"/> Dependent ceasing to qualify under the plan<br><input type="checkbox"/> Employer bankruptcy under Title II |
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Qualifying Event Date	Last Date of Coverage by Employer	COBRA Start Date	COBRA End Date
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**SECTION B - List of Continuing UnitedHealthcare of California Members/Enrollees Only**

Please complete for continuing members (beneficiaries) who will be continuing coverage. If applicable, include employee.

#	Self	Last Name	Social Security Number	Street Address	Primary Care Physician Name	
1	Sex M or F	First Name	M.I.	Date of Birth (Month - Day - Year)	City State Zip	Medical Group Name
	2	Spouse	Last Name	Social Security Number	Street Address	Primary Care Physician Name
Sex M or F			First Name	M.I.	Date of Birth (Month - Day - Year)	City State Zip
3	Relationship	Last Name	Social Security Number	Street Address	Primary Care Physician Name	
	Sex M or F	First Name	M.I.	Date of Birth (Month - Day - Year)	City State Zip	Medical Group Name
4	Relationship	Last Name	Social Security Number	Street Address	Primary Care Physician Name	
	Sex M or F	First Name	M.I.	Date of Birth (Month - Day - Year)	City State Zip	Medical Group Name
5	Relationship	Last Name	Social Security Number	Street Address	Primary Care Physician Name	
	Sex M or F	First Name	M.I.	Date of Birth (Month - Day - Year)	City State Zip	Medical Group Name

**Benefit Coordination/Other Insurance Carrier Information**

1. Does anyone listed have other health insurance?  Yes  No If yes, complete section below.
2. Is anyone listed permanently disabled?  Yes  No Name \_\_\_\_\_ Date disability began \_\_\_\_\_
3. Is anyone listed eligible for Medicare?  Yes  No Name \_\_\_\_\_ Medicare ID# \_\_\_\_\_

NAME	INSURANCE COMPANY NAME	POLICY NO. & EFFECTIVE DATE	OTHER EMPLOYER NAME & ADDRESS

Member/Enrollee Signature	Date
Employer Signature	Date

**UnitedHealthcare SignatureValue™ (HMO),  
 UnitedHealthcare SignatureValue™ Advantage (HMO  
 Value Network):**  
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