PacifiCare®
Dental & Vision

COBRA Election Form

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

Subscriber ID #

When appropriate, attach a completed Member Enrollment/Change of Status Form to this COBRA Election Form

Employer Name	Group Number

COBRA Information (To be completed by employer)

Member/Enrollee Last Name	First	M.I.

Is the member/enrollee a current Dental Benefit Providers of California, Inc. ("DBP-CA") and PacifiCare Vision Administrators member/enrollee?

M Yes Please enter the Subscriber ID Number in the box in the upper right of this form and complete Sections A and B of this form.

M No Please complete Section A only of this form and attach a completed Member Enrollment/Change of Status 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)

Termination or reduction in hours of employment
Death of employee
Divorce or legal separation
Loss of coverage due to employee Medicare entitlement
Dependent ceasing to qualify under the plan
Employer bankruptcy under Title II

Qualifying Event Date	Last Date of Coverage by Employer	COBRA Start Date	COBRA End Date

SECTION B – List of Continuing Members/Enrollees Only

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

#		Name	Social Security Number / Date of Birth	Address	DBP-CA SignatureValue® (HMO) ONLY
1	Self	Last Name	Social Security Number - -	Street Address	Provider Group #
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP	
2	Spouse	Last Name	Social Security Number - -	Street Address	Provider Group #
	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	Provider Group #
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP	
4	Relationship	Last Name	Social Security Number - -	Street Address	Provider Group #
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP	
5	Relationship	Last Name	Social Security Number - -	Street Address	Provider Group #
	Sex M or F	First Name M.I.	Date of Birth (Month - Day - Year) - -	City State ZIP	

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# ________ M - D - Y

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

Member/Enrollee Signature	*Date*	*Employer Signature*	*Date*

Attn: Employer Groups, MAS, CA1520342
Dental Benefit Providers of California, Inc. and PacifiCare Vision Administrators
P.O. Box 25187
Santa Ana, CA 92799-5187
Phone: (714) 513-6494 or 1-800-622-6388 option #4