

Employer Group Reporting Form



- Please complete information below and provide to PacifiCare, a UnitedHealthcare Company, within 30 days from effective date one of the following ways:

Employer Name
Group Number(s)

E-mail this form to:
imaging_elig@phs.com

Fax this form* to:
1-866-372-1316

Mail this form to:
P.O. Box 30981
Salt Lake City, UT
84130-0981

Overnight delivery to:
PacifiCare Eligibility
4050 South 500 West
Salt Lake City, UT 84123
1-801-262-1270

- 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.

Important Notice for Small Business Employers With 2-19 Employees: You must submit a *Cal-COBRA Qualifying Event Notice Form* for each terminated employee who has expressed interest in exercising their rights under Cal-COBRA.

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 SecureHorizons®
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
	LM Lifetime Maximum Exceeded

Employer (Print Name)	Employer Signature	Telephone	Date
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