UnitedHealthcare
Healing health care. Together.

Involuntarily Terminated Member Identification Form – CO

Please Submit Completed Form to:
UnitedHealthcare
Attention: ARRA Cobra Update Team
PO Box 30964
Salt Lake City, UT 84130-0964

Please complete the following information for the Employer	**Policy Name:**		
	Policy Number:	**Employer Tax Identification Number:**	
	Contact Name:	**Contact Phone:**	
	Employer Billing Address:		

Employee Information

Please provide the following information for each employee who had a qualifying event on or after September 1st, 2008, including indication as to whether the employee was involuntarily terminated.

Employee or Participant Full Name:	Relationship: (i.e. spouse, child) Subscriber Identification Number: (blank if not known)
Employee or Participant Street Address:	City:
State:	Zip:
Employee or Participant SSN#:	Telephone Number(s):
Date of Qualifying Event (M/D/Y):	Date of Termination (M/D/Y):

**Was the Employee Involuntarily Terminated?

Is the Employee or Participant Currently Enrolled in Employer's Group Coverage through a State Continuation Law?

Date Employee was Notified of Termination Rights: (blank if not known)

Start Date of Continuation (if already on continuation): (blank if not known)

End Date of Continuation (if already on continuation): (blank if not known)

Employer Premium Contribution Amount: (leave blank if no part of the state continuation is paid by Employer)

Employer Contact Signature: Date:

***For guidelines on definitions of "Involuntarily Terminated" employees, please refer to guidance released from United States Department of Labor (http://www.dol.gov/ebsa/cobra.html)*