Employer Group Reporting Form

UnitedHealthcare®

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

Employer Name
Group Number(s)

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

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

Overnight delivery to:
West Region Eligibility
4050 South 500 West
Salt Lake City, UT 84123
(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 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)	ID # or SSN	HMO (H) PPO (P) Life (L)	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	47	Expired COBRA Benefits
02	Deceased	LE	Left Employment
07	Other Insurance Benefits Available	DV	Divorce
16	Failure to Pay / Copay Premium	ER	Enrolled in Error
37	Multiple ID Numbers	48	Voluntary — No Reason Given
42	Not Enough Hours	LM	Lifetime Maximum Exceeded
43	Transferred to UnitedHealthcare Medicare Solutions		

Employer (Print Name)	Employer Signature	Telephone	Date

*PLEASE RETAIN A COPY OF FAX CONFIRMATION SHEET AS PROOF OF SUBMISSION.

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