Employer Group Reporting Form

UnitedHealthcare®

Employer Name
Group Number(s)

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

E-mail this form to:
imaging_elig@uhc.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:
West Region 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)	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	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

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