COBRA Administration

Notice of New Employee

(Please fax completed form to 336-759-3999. Please Print!)

Company Name: ____

Employee Last Name: ______________________________ First Name: ___________________ Middle Initial:______

Employee Address: ____

City: _______________________________ State: ______ Zip: _____________

Employee SSN: ___________________________ DOB: _________________________________ Sex: ❑ M ❑ F

Please provide the following dates:

Date of **this Notice**: _______________________

Date **Employee Hired**: _______________________

Initial Date of **Health Insurance** Coverage: _______________________ [❑ Non-applicable]

Initial Date of **Dental Insurance** Coverage: _______________________ [❑ Non-applicable]

Initial Date of **Vision Plan** Coverage: _______________________ [❑ Non-applicable]

Initial Date of **Section 125 / FSA Plan** Coverage: _______________________ [❑ Non-applicable]

Initial Date of **HRA Plan** Coverage: _______________________ [❑ Non-applicable]

Please list full names of Spouse and/or Dependents covered under the following:

Group **Health Insurance**: ____

____

Group **Dental Insurance**: ____

____

Group **Vision Plan**: ____

____

Form prepared by: ____________________________________

Phone: (________) __________________________________

Email: ____

Comments: ____

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