COBRA Administration

NEWLY COVERED EMPLOYEE INFORMATION REQUEST FORM

(Revised 07/01/15)

Employer Name: _____

Employee Name: _____

Residence Mailing Address: _____

Residence City, State, ZIP: _____

Social Security #: _____

Date of Birth: _____

Date of Hire: _____

Date Coverage Effective: _____

English or Spanish Notice: English: ___ Spanish: ___

Health Insurance Plan Selected: _____

Employee Only: ___ EE & Spouse: ___ EE & Children: ___ Family: ___ **WAIVED:** ___

Dental Insurance Plan Selected: _____

Employee Only: ___ EE & Spouse: ___ EE & Children: ___ Family: ___ **WAIVED:** ___

Other Insurance Plan Selected:
(Vision, Chiropractic, Mental Health): _____

Employee Only: ___ EE & Spouse: ___ EE & Children: ___ Family: ___ **WAIVED:** ___

Flexible Spending Plan: _____

Spouse Name: _____

Children's Names: _____

Different Address for Dependents?: _____

Fax this form to: **(877) 901-5522**

or

email this form to: cobra@ua-insurance.com

United Agencies Inc. INSURANCE

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