

## **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:	_
<b>Health Insurance</b> Plan Selected:		
Employee Only: EE & Spou	e: EE & Children: Fam	ily: <b>WAIVED:</b>
Dental Insurance Plan Selected:		
Employee Only: EE & Spou	e: EE & Children: Fam	ily: <b>WAIVED:</b>
Other Insurance Plan Selected: (Vision, Chiropractic, Mental Health		
Employee Only: EE & Spou	e: EE & Children: Fam	ily: <b>WAIVED:</b>
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

