NEWLY COVERED EMPLOYEE INFORMATION REQUEST FORM

(Revised 03/01/09)

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@unitedagencies.com

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