

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: \_\_\_\_\_  
\_\_\_\_\_



Savers Administrative Services • 635 W. Fourth St., Suite 201 • Winston-Salem, NC 27101-2740  
ph: 336-759-3888 • toll free: 800-949-0311 • fax: 336-759-3999 • www.saversadmin.com