REQUEST FOR GENERAL INITIAL NOTICE OF COBRA RIGHTS

For fastest processing, submit this form online via support request. You may also use one of the following methods:	Fax	Mail
	608-245-3623	BASIC, PO Box 14015 Madison, WI 53708-0015

EMPLOYER INFORMATION

Employer Name		Employer ID (12-digit)	
Division		Class	
Contact Name		Contact Phone	

NEW HEALTH PLAN COVERED EMPLOYEE OR DEPENDENT

First Name		MI		Last Name			
Date of Hire				Employee ID			
Gender	☐ Female ☐ Male ☐ Other			Date of Birth			
Primary Email				Primary Phone			
Primary Address	Address 1						
	Address 2						
	City						
	State			ZIP		+4	

DEPENDENTS COVERED

First Name	Last Name	Address	City	State	ZIP

AUTHORIZATION

Name

Email

Signature

Date

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