

COBRA Initial Notification

IMPORTANT: Please complete and return this form to ASI - our contact information is provided below:
This form is to be completed for actively working employees who are enrolled into COBRA eligible benefits plan(s).

Employer Name: _____

Name of Employee: _____

Employee Date of Birth: _____

Employee First Date of Coverage: _____

Employee SSN #: _____

Employee Mailing Address: _____

Name of Spouse: _____ Date of Birth: _____

Dependent: _____ Date of Birth: _____

Dependent: _____ Date of Birth: _____

Dependent: _____ Date of Birth: _____

Dependent: _____ Date of Birth: _____

Spouse / Dependent's Address if Different from Employee:

Signature of Employer or Employer Representative

Date



Administrative Solutions, Inc.
P.O. Box 5809
Fresno CA 93755-5809
Telephone 559 256-1320 Toll Free 866 777-1320
Fax: 559 256-1321 Email: cobradepartment@asibenefits.com