

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

Ph. 559.256.1320 / Toll Free 866.777.1320

Fax 559.475.5781 / cobradepartment@asibenefits.com

Current/Pending COBRA Participant

Instructions: This form requires completion for those who are enrolled into COBRA at the time the group becomes effective with ASI and should be sent to our office. This form should also be completed and sent to our office for anyone previously notified of their COBRA rights and currently in their election window. Please see out contact information below.

Employer Name: _____

Name of Primary Beneficiary: _____ **Beneficiary's Social Security #:** _____

First Date of Coverage: _____ **Beneficiary's Mailing Address:** _____
(Active Group Coverage)

Qualifying Event Information:

- Primary Beneficiary's Qualifying Event: Termination Reduction of hours
 Resignation/Retirement
- Dependent Qualifying Event: Divorce or legal separation Death of covered employee
 Child no longer eligible

Current COBRA

Paid Through Date: _____
(Date the beneficiary's COBRA premium is paid through)

Date of the Qualifying Event: _____

Pending COBRA

60-Day Election Period Begins: _____
(What date was the election letter sent?)

45-Day Election Period Begins: _____
(What date was the election made?)

Qualified Beneficiaries:

- Employee Name: _____ Date of Birth: _____
- Spouse Name: _____ Date of Birth: _____
- Dep Child Name: _____ Date of Birth: _____
- Dep Child Name: _____ Date of Birth: _____
- Dep Child Name: _____ Date of Birth: _____
- Dep Child Name: _____ Date of Birth: _____

Spouse or Dependent Address:

(Complete if address is different than the primary beneficiary's address above)

Health Plans:

- Medical Carrier: _____ Rate Area: _____
- Dental Carrier: _____ Rate Area: _____
- Vision Carrier: _____ Rate Area: _____
- Other Plan/Carrier: _____ Rate Area: _____
- Section 125 Plan: _____ Election Amount and Balance: _____
(Amount) (Balance)

(Signature of Employer or Employer Representative)

(Date)



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COBRA Notice of Qualifying Event

Instructions: To notify ASI of an employee who has lost coverage or has had a COBRA qualifying event, please return this completed form to our office. Our contact information is below.

Employer Name: _____

Name of Primary Beneficiary: _____ **Beneficiary's Social Security #:** _____

First Date of Coverage: _____ **Beneficiary's Mailing Address:** _____

Qualifying Event Information: _____

Primary Beneficiary's Qualifying Event: Termination Reduction of hours
 Resignation/Retirement

Dependent Qualifying Event: Divorce or legal separation Death of covered employee
 Child no longer eligible

Date of the Qualifying Event: _____
 Date loss of coverage began or date of termination.

Qualified Beneficiaries:

Employee Name: _____ Date of Birth: _____
(COBRA Beneficiary)

Spouse Name: _____ Date of Birth: _____

Dep Child Name: _____ Date of Birth: _____

Dep Child Name: _____ Date of Birth: _____

Dep Child Name: _____ Date of Birth: _____

Dep Child Name: _____ Date of Birth: _____

Spouse or Dependent Address:
 Complete if address is different than the primary beneficiary's address above.

Health Plans:

Medical Carrier: _____ Rate Area: _____

Dental Carrier: _____ Rate Area: _____

Vision Carrier: _____ Rate Area: _____

Other Plan/Carrier: _____ Rate Area: _____

Section 125 Plan: _____ Election Amount and Balance: _____

Amount Balance

 Signature of employer or employer representative

 Date



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