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)

Administrative Solutions, Inc.
P. O. Box 5809, Fresno, CA 93755-5809
Ph. 559.256.1326 / Toll Free 866.777.1320
Fax 559.457.5781 / cobradepartment@asibenefits.com

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: (COBRA Beneficiary)	_____	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

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