# 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<br>Madison, WI 53708-0015 |

## CLIENT/EMPLOYER INFORMATION

| Client/Employer Name: | | Employer ID (12-digit): | |
|---|---|---|---|
| Client/Employer Email: | | Client/Employer Phone: | |

## NEW HEALTH PLAN COVERED EMPLOYEE OR DEPENDENT

| First Name: | | MI: | | Last Name: | |
|---|---|---|---|---|---|
| Date of Birth: | | Gender: | ☐ Female ☐ Male ☐ Other | | |
| Date of Hire: | | Employee ID: *(optional)* | | | |
| Primary Phone: | | Email Address: | | | |
| Primary Address: | Address 1: | | | Apt: | |
| | Address 2: | | | | |
| | City: | | | | |
| | State: | | ZIP Code: | | +4: |

## DEPENDENTS COVERED

| Spouse First Name: | | MI: | | Last Name: | | | |
|---|---|---|---|---|---|---|---|
| Address: | | City: | | State: | | ZIP: | |

| First Name: | | MI: | | Last Name: | | | |
|---|---|---|---|---|---|---|---|
| Address: | | City: | | State: | | ZIP: | |

| First Name: | | MI: | | Last Name: | | | |
|---|---|---|---|---|---|---|---|
| Address: | | City: | | State: | | ZIP: | |

| First Name: | | MI: | | Last Name: | | | |
|---|---|---|---|---|---|---|---|
| Address: | | City: | | State: | | ZIP: | |

## SUBMITTED BY

**Print Name** **Title**

**Signature** **Date**



*The information contained in this document is confidential and to be used by BASIC employees and representatives for only its intended purpose.*

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