



# COBRA GENERAL NOTICE REQUEST

(For New Hires and/or Adding Dependents)  
(New Spouse, Newborns, and Adopted Children)

North American  
Benefits Company

Suite 310  
20 Valley Stream Parkway  
Malvern, Pennsylvania 19087

Email: cobra @nabenefits.com  
Phone: 610-995-0169

**Employer Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Completed By: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

**Employee Information:** \_\_\_\_\_ **Date of Hire (employee only):** \_\_\_\_\_

Employee Name (First, Last, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Billing Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

### Name of Plan(s) and Coverage:

	<input type="checkbox"/> Health	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision
Carrier Name:			
Plan Description:			
Coverage Level:			
Effective Date:			

- Coverage level examples:
- Single
  - Employee & Spouse
  - Employee & Child(ren)
  - Family

Has General Notice already been provided by employer:  No  Yes *(If yes, provide date):* \_\_\_\_\_

Please check if General Notice should be provided in Spanish for this employee.

### Spouse Information: (If the employee has a spouse who will be enrolled on the plan, enter information below)

Name (First, Last, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Benefit Start Date \_\_\_\_\_

Address if different than employee: \_\_\_\_\_

### Children's Information: (If the employee has children who will be enrolled on the plan, enter information below)

1. Name (First, Last, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Benefit Start Date \_\_\_\_\_

Address if different than employee: \_\_\_\_\_

2. Name (First, Last, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Benefit Start Date \_\_\_\_\_

Address if different than employee: \_\_\_\_\_

3. Name (First, Last, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Benefit Start Date \_\_\_\_\_

Address if different than employee: \_\_\_\_\_

4. Name (First, Last, MI) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Benefit Start Date \_\_\_\_\_

Address if different than employee: \_\_\_\_\_