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COBRA Initial Rights Notification Form

TO BE COMPLETED BY EMPLOYER

How to File: By email: COBRAdivision@flex-admin.com
 By Secure File Transfer: <https://securefile.flex-admin.com/>
 By fax: (757) 431-1155

EMPLOYEE INFO: *optional field

EMPLOYER:			DIVISION:			
*Salutation:	FIRST:	*MI:	LAST:			
ADDRESS:			CITY:	ST:	ZIP:	
D. O. B:		GENDER:		SOCIAL SECURITY #:		
*Phone:		*Email:				
*Benefit Plan Coverage Level:				*Coverage Began Date:		

EMPLOYEE INFO: *optional field

EMPLOYER:			DIVISION:			
*Salutation:	FIRST:	*MI:	LAST:			
ADDRESS:			CITY:	ST:	ZIP:	
D. O. B:		GENDER:		SOCIAL SECURITY #:		
*Phone:		*Email:				
*Benefit Plan Coverage Level:				*Coverage Began Date:		

EMPLOYEE INFO: *optional field

EMPLOYER:			DIVISION:			
*Salutation:	FIRST:	*MI:	LAST:			
ADDRESS:			CITY:	ST:	ZIP:	
D. O. B:		GENDER:		SOCIAL SECURITY #:		
*Phone:		*Email:				
*Benefit Plan Coverage Level:				*Coverage Began Date:		

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