



P.O. Box 43653 Louisville, KY 40253-0653  
 (502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 [www.bmsllc.net](http://www.bmsllc.net)  
**COBRA Newly Eligible Form**

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_

Date of Hire: \_\_\_\_\_ Benefit Begin Date: \_\_\_\_\_

Qualified Beneficiaries	Relationship to Employee	Date of Birth	Social Security Number

~~~~~	Health Insurance	Carrier Name & Plan Name	Monthly Premium
	Employee Only		
	Employee + Child(ren)		
	Employee + Spouse		
	Family		

~~~~~	Dental Insurance	Carrier Name & Plan Name	Monthly Premium
	Employee Only		
	Employee + Child(ren)		
	Employee + Spouse		
	Family		

\_\_\_\_\_ Other (Please note if: FSA, HRA, Vision, EAP, Etc.)

Please notify the Plan Sponsor (BMS LLC) within 10 days of all new hires or new benefit elections in order for them to be added to the system timely and to process Initial Notices in a timely manner. **Please be sure to notify us of all address changes as well!**

Employer's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Company Name: \_\_\_\_\_

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Please return this form to:  
 BMS LLC – Attn: COBRA Administrator Fax (502) 244-1162 or e-mail: [cobra@bmsllc.net](mailto:cobra@bmsllc.net) or  
 Enter Online at: [www.MyTPAOnline.com](http://www.MyTPAOnline.com)

Accepted and Completed by BMS LLC Rep: \_\_\_\_\_ Date: \_\_\_\_\_