COBRA NEWLY ELIGIBLE FORM

Enter Online at www.MyTPAOnline.com

or return completed form to
cobra@bmsllc.net or Fax (502) 244-1162

P.O. Box 43653 Louisville, KY 40253-0653
PHONE (502) 244-1161 www.bmsllc.net

COMPANY NAME: ______________________________

EMPLOYEE INFORMATION

☐ Male ☐ Female

First **M.I.** **Last** **Gender**

Street Address **Apartment/Unit #**

City **State** **Zip Code**

Social Security # **Date of Birth**

Date of Hire **Benefit Begin Date**

QUALIFIED BENEFICIARIES/COVERED DEPENDENTS

Name	Social Security #	Birth Date	Relationship	Full-time Student
			☐ Spouse ☐ Child	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No
			☐ Child ☐ Other	☐ Yes ☐ No

EMPLOYEE ENROLLMENT

HEALTH INSURANCE Carrier:	DENTAL INSURANCE Carrier:	VISION INSURANCE Carrier:
Plan Name: ____________	Plan Name: ____________	Plan Name: ____________
Type of Coverage ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family	Type of Coverage ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family	Type of Coverage ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
Monthly Premium: $____________	Monthly Premium: $____________	Monthly Premium: $____________

HEALTH REIMBURSEMENT ARRANGEMENT Carrier:	MEDICAL SPENDING ACCOUNT (FSA) Carrier:	OTHER COBRA ELIGIBLE GROUP PLAN Carrier:
Plan Name: ____________	Plan Name: ____________	Plan Name: ____________
Type of Coverage ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family		Type of Coverage ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family
Monthly Premium: $____________	Monthly Contribution: $____________	Monthly Premium: $____________

Please notify BMS within thirty days of all new hires and/or new benefit elections to allow ample time for enrollment enter and processing of the required General Notice.
NOTE: Address changes must also be reported to BMS to maintain accurate records.

Employer's Signature: ______________________________ Date: ______________

Accepted and Completed by BMS LLC Representative: ______________________________ *Date:* ______________