P.O. Box 43653 Louisville, KY 40253-0653
(502) 244-1161 (800) 919-BMSI FAX (502) 244-1162 ***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 or
Enter Online at: www.MyTPAOnline.com

Accepted and Completed by BMS LLC Rep: _____ Date: _____
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