TOWNE BENEFITS

COBRA Initial Rights Notification

Effective Date _____

Company Name_____

Employee Name _____ SSN_____

Mailing
Address_____

Name of
Spouse_____

Covered Dependents Other Than Spouse

Name_____ Relationship_____
Mailing Address
(if different than Employee)_____

Name_____ Relationship_____
Mailing Address
(if different than Employee)_____

Benefit Coverage

Health _____Coverage Level _____

Dental_____ Coverage Level_____

Vision_____ Coverage Level_____

FSA_____

Prepared by:_____

Email to: Cobra@TowneBenefits.com