



Request for General Initial Notice of COBRA Rights

For fastest processing, submit this form online via support request. You may also use one of the following methods:	Fax	Mail
	608-245-3623	TASC, PO Box 14015 Madison, WI 53708-0015

CLIENT/EMPLOYER INFORMATION

Client/Employer Name:		TASC ID (12-digit):	
Client/Employer Email:		Client/Employer Phone:	

NEW HEALTH PLAN COVERED EMPLOYEE OR DEPENDENT

First Name:		MI:		Last Name:		
Date of Birth:		Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other			
Date of Hire:		Employee ID: (optional)				
Primary Phone:		Email Address:				
Primary Address:	Address 1:				Apt:	
	Address 2:					
	City:					
	State:		ZIP Code:		+4:	

DEPENDENTS COVERED

Spouse First Name:		MI:		Last Name:	
Address:		City:		State:	
ZIP:					
First Name:		MI:		Last Name:	
Address:		City:		State:	
ZIP:					
First Name:		MI:		Last Name:	
Address:		City:		State:	
ZIP:					
First Name:		MI:		Last Name:	
Address:		City:		State:	
ZIP:					

SUBMITTED BY

Print Name

Title

Signature

Date

TASC | 2302 International Lane | Madison, WI 53704-3140 | 800-422-4661 | www.tasconline.com | CO-3458-041823

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