Benefits*Direct*

New Hire Notification Form

Employer Name: ____

Employee Name: ______________________________ Date of Birth: ________________________
Address: ____
City: ____________________________________ State: ______________ Zip: ______________________
SSN#: _________________________________ Gender: ☐ M ☐ F
Date of Hire: ______________ Occupation: ____
Salary: ___________________ Email: ____
Work Phone: __________________________ Home Phone: _____________________________
Cell Number: ____________________ Elected Group Health Plan Coverage:* ☐ Y ☐ N

Employee Name: ______________________________ Date of Birth: ________________________
Address: ____
City: ____________________________________ State: ______________ Zip: ______________________
SSN#: _________________________________ Gender: ☐ M ☐ F
Date of Hire: ______________ Occupation: ____
Salary: ___________________ Email: ____
Work Phone: __________________________ Home Phone: _____________________________
Cell Number: ____________________ Elected Group Health Plan Coverage:* ☐ Y ☐ N

Employee Name: ______________________________ Date of Birth: ________________________
Address: ____
City: ____________________________________ State: ______________ Zip: ______________________
SSN#: _________________________________ Gender: ☐ M ☐ F
Date of Hire: ______________ Occupation: ____
Salary: ___________________ Email: ____
Work Phone: __________________________ Home Phone: _____________________________
Cell Number: ____________________ Elected Group Health Plan Coverage:* ☐ Y ☐ N

Employee Name: ______________________________ Date of Birth: ________________________
Address: ____
City: ____________________________________ State: ______________ Zip: ______________________
SSN#: _________________________________ Gender: ☐ M ☐ F
Date of Hire: ______________ Occupation: ____
Salary: ___________________ Email: ____
Work Phone: __________________________ Home Phone: _____________________________
Cell Number: ____________________ Elected Group Health Plan Coverage:* ☐ Y ☐ N

***Only required for groups using Benefits-Direct COBRA services**

Authorization: ____________________________________ **Date:** ____________________

Please return this form to Jeff Stoppel at jstoppel@benefits-direct.com