

**AITA AND ASSOCIATES
ACTION REQUEST FORM**

DATE: _____

GROUP NAME: _____

ACTION REQUESTED: _____

Add:

a. NEW HIRE

Name: _____

Job Classification (circle one): Management Staff

Date of Hire: _____ Effective Date: _____

Plan (circle applicable plan(s): Health Net Delta Dental

Was COBRA Initial Notification sent to new hire? Yes _____ No _____

b. DEPENDENT

Employee Name: _____

Qualifying Event :

New marriage - Date of Marriage: _____

Newborn child - Date of Birth: _____

Newly adopted child - Date of adoption: _____

Loss of prior group coverage (*Please submit proof of loss of coverage*)

Date of loss: _____

2. Delete:

a. TERMINATED EMPLOYEE

Name: _____

Date of Termination: _____

Was COBRA Notice sent to terminated employee? Yes _____ No _____

b. DEPENDENT

Employee Name: _____

Dependent(s) to be deleted: _____

Reason for deletion: _____

Effective date of deletion: _____

If dependent is terminated due to overage or divorce, was a COBRA notice sent?

Yes _____ No _____

Please fax back , along with applicable forms, to 707-829-8924.

DON'T FORGET TO SEND ORIGINALS TODAY to:

Aita & Associates

7005 Hazel Cotter Ct #G3

Sebastopol, CA 95472

Thank you!