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Mercer Marketplace 365+

COBRA Addition of Dependent Form

This form is to add any dependents to your coverage.

* = Required Fields

The addition of dependents is being requested as a result of the following:

☐ Marriage ☐ Birth ☐ Adoption ☐ Loss of Coverage ☐ Loss of Medicaid/CHIP Coverage

Depending on the reason for the addition of dependents, your insurance carriers may require additional documentation. Please include a copy of the marriage certificate, birth certificate, adoption decree, certificate of coverage, or termination of coverage notice (respectively).

This form must be submitted to WEX within 30 days of marriage, birth, adoption or loss of group coverage, or within 60 days of loss of Medicaid/CHIP coverage, even if you are not yet able to include the supporting documentation.

Step 1: Primary Qualified Beneficiary Information

*Primary Qualified Beneficiary Name (First, MI, Last)

*Social Security Number ___ - ___ - ____

*Day Telephone ___ - ___ - ____

Email Address

*Previous Employer (Do not abbreviate)

Step 2: Dependent Information

Spouse Information

*Spouse Name (First, MI, Last)

*Social Security Number ___ - ___ - ____

*Date of Birth (mm/dd/yyyy)

☐ M/F/U

*Gender

*Date of Marriage (mm/dd/yyyy)

*Please add the above dependent to the following plans:

☐ Medical ☐ Dental ☐ Vision ☐ Other

COBRA Addition of Dependent Form, continued

Child(ren) Information

*Child Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

M/F/U

*Gender

*Please add the above dependent to the following plans:

Medical Dental Vision Other

*Child Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

M/F/U

*Gender

*Please add the above dependent to the following plans:

Medical Dental Vision Other

Child(ren) Information, continued

*Child Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

M/F/U

*Gender

*Please add the above dependent to the following plans:

Medical Dental Vision Other

Step 3: Primary Qualified Beneficiary Cerification

I understand submission of this form is to add one or more qualifying dependents to my COBRA continuation coverage. Further, I understand the addition of any dependents may affect my monthly premiums.

*Primary Qualified Beneficiary Signature

*Date