Newly Covered Employee/Spouse

Discovery Benefits
COBRA

Employer

Newly Covered Employee ☐ Newly Covered Spouse ☐

1. Employee Information

Name (First, Middle Initial, Last)

Female ☐ Male ☐

Date of Birth

Social Security Number

Address

Phone

City

State

Zip

	Other Family Member Names (at same address)	Relationship	Social Security Number	Date of Birth
1				
2				
3				

Please attach sheet for additional Family Members at same address.

2. Current Benefits

☐ **Health**
- Contract Number
- Original Effective Date
- Last Date of Coverage

☐ **Dental**
- Contract Number
- Original Effective Date
- Last Date of Coverage

☐ **Vision**
- Contract Number
- Original Effective Date
- Last Date of Coverage

☐ **Medical Spending Account**
- Annual Election $
- Monthly Deduction $
- Amount Paid YTD $
- Pending Reimbursement $
- Last Date of Coverage
- Original Effective Date

☐ **Other Health Plan**
- Description
- Original Effective Date
- Last Date of Coverage
- Level of Coverage
- Monthly Premium $

☐ **Life Insurance**
- Original Effective Date
- Last Date of Coverage
- Premium Amount $
- Face Amount $

☐ **Medicare Coverage**

Yes ☐ No ☐

If yes, Effective Date

Please note: Original effective date of coverage is required for all benefits due to the requirements included in the Health Insurance and Accountability Act.

3. Completed By

Name (First, Middle Initial, Last)

Date

Phone