Discovery Benefits
FSA • HSA • HRA • COBRA • Transportation

www.DiscoveryBenefits.com
Phone: 866-451-3399 • Fax: 888-408-7224
PO Box 869 • Fargo, ND 58107-0869
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COBRA Addition of a Dependent Form

This form is to add any dependents to your coverage.

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

	Marriage		Birth		Adoption		Loss of 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, or certificate of coverage, respectively.

Notification of additional dependents must be made within 30 days of the qualifying event or loss of coverage by submission of this completed form regardless of whether or not the additional documentation can also be provided within that timeframe.

Step 1: Primary Qualified Beneficiary Information

*=Required Fields

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

*Social Security Number ___ - __ - ____

*Previous Employer (Do not abbreviate)

*Day Telephone ___ - ___ - ____

Email Address

Step 2: Dependent Information

Spouse Information

*Spouse Name (First, MI, Last)

*Social Security Number ___ - __ - ____

*Date of Birth (mm/dd/yyyy)

Male	Female

*Gender (Circle one)

*Date of Marriage (mm/dd/yyyy)

*Please add the above dependent to the following plans:

	Medical		Dental		Vision		Other (__________)

Child(ren) Information

*Child Name (First, MI, Last)

*Social Security Number ___ - __ - ____

*Date of Birth (mm/dd/yyyy)

Male	Female

*Gender (Circle one)

*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)

Male	Female

*Gender (Circle one)

*Please add the above dependent to the following plans:

	Medical		Dental		Vision		Other (__________)

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COBRA Addition of a Dependent Form

*Child Name (First, MI, Last)

*Social Security Number ___ - __ - ____

*Date of Birth (mm/dd/yyyy)

Male	Female

*Gender (Circle one)

*Please add the above dependent to the following plans:

	Medical		Dental		Vision		Other (__________)

Step 3: Primary Qualified Beneficiary Certification

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