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# COBRA Addition of a Dependent Form

This form is to add any dependents to your coverage.

*=Required Fields

## Step 1: Primary Qualified Beneficiary Information

*Primary Qualified Beneficiary Name (First, MI, Last) - - *Social Security Number

*Employer Sponsoring Benefits (Do not abbreviate)

- - *Day Telephone Email Address

## Step 2: Dependent Information

The addition of dependents is being requested as a result of the following: Marriage Birth Adoption Loss of Coverage

Date of Event (mm/dd/yyyy)

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 2a: Spouse Information

*Spouse Name (First, MI, Last) - - *Social Security Number

*Date of Birth (mm/dd/yyyy) *Gender (M/F)

*Please add the above dependent to the following plans:

Medical Dental Vision Other ( ______________________ )

## Step 2b: Child(ren) Information

*Child Name (First, MI, Last) - - *Social Security Number

*Date of Birth (mm/dd/yyyy) *Gender (M/F)

*Please add the above dependent to the following plans:

Medical Dental Vision Other ( ______________________ )

Continued on next page

# COBRA Addition of a Dependent Form, continued

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*Child Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

*Gender (M/F)

*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)

*Gender (M/F)

*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