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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

1Daniel, P, Gillette — *Primary Qualified Beneficiary Name (First, MI, Last)

646-07-8341 — *Social Security Number

Fashionphile — *Employer Sponsoring Benefits (Do not abbreviate)

801-441-9900 — *Day Telephone

dgillette25@gmail.com — 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) 04/03/2023

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/U)

*Please add the above dependent to the following plans:

☐ Medical ☐ Dental ☐ Vision ☐ Other (_____)

Step 2b: Child(ren) Information

Sloane, N, Gillette — *Child Name (First, MI, Last)

888-06-8225 — *Social Security Number

04/03/2023 — *Date of Birth (mm/dd/yyyy)

F — *Gender (M/F/U)

*Please add the above dependent to the following plans:

☑ Medical ☑ Dental ☑ Vision ☐ Other (_____)

Continued on next page

COBRA Addition of a Dependent Form, continued

*Child Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

*Gender (M/F/U)

*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/U)

*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

04/29/2023

*Date