

Addition of a dependent form



Use this form to add dependents to your coverage. If the additional dependent is due to a marriage, birth, or adoption (qualifying event), notification of the additional dependent must be made within 30 days of this qualifying event.

1. Primary beneficiary information

Primary qualified beneficiary name (first, MI, last) _____
Social Security number _____ Previous employer (Do not abbreviate) _____
Phone _____ Email address _____

2. Dependent information

If adding a spouse, please complete Step 2a. If adding one or more children, please complete Step 2b.

2a: Spouse information

Spouse name (first, MI, last) _____ Social Security number _____
Date of birth (mm/dd/yyyy) _____ Date of marriage (mm/dd/yyyy) _____
Please add the above dependent to the following plans:
Medical Dental Vision Other: _____

2b: Child or children information

Child name (first, MI, last) _____ Social Security number _____
Date of birth (mm/dd/yyyy) _____
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) _____
Please add the above dependent to the following plans:
Medical Dental Vision Other: _____

3. Primary beneficiary certification

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

Primary beneficiary signature _____ Date _____

Please send this form to PacificSource Administrators and retain a copy for your records.

- COBRA@PacificSource.com
- Mail to PSA, PO Box 71096, Springfield OR 97475
- Fax: **541-225-3684**

Questions? Email us or call **877-355-2760**, TTY: 711. We accept all relay calls.