PacificSource.com/PSA
Phone: (877) 355-2760 Fax: (541) 225-3684
PO Box 71096, Springfield, OR 97475-0182
cobra@pacificsource.com

Special Plan Member Information Form

*= Required Fields

Step 1: Employee Information

*Employer Name (do not abbreviate)

*Division Name (if applicable)

What type of billing will be provided for this participant:

☐ Retiree Billing ☐ FMLA ☐ Leave of Absence ☐ Other (please indicate):

*Billing Start Date (mm/dd/yyyy) Billing End Date (mm/dd/yyyy)

*Employee Name (First, MI, Last) *Gender (M/F)

*Date of Birth (mm/dd/yyyy) *Hire Date (mm/dd/yyyy) *Social Security Number

*Mailing Address Daytime Phone

*City *State *Zip

Step 2: Current Benefits

☐ **Health**

*Health Carrier Name
*Plan Description
*Coverage Level
*Original Effective Date

☐ **Dental**

*Dental Carrier Name
*Plan Description
*Coverage Level
*Original Effective Date

☐ **Vision**

*Vision Carrier Name
*Plan Description
*Coverage Level
*Original Effective Date

☐ **Medical Spending Account**

*Monthly Rate $
*Benefit Last Date of Coverage
*Plan Year Start Date
*Plan Year End Date

☐ **Other Health Plan**

*Carrier Name
*Plan Description
*Coverage Level
*Original Effective Date

☐ **Life Insurance**

*Face Amount $
*Premium Amount $
*Last Date of Coverage
*Original Effective Date

Step 3: Other Covered Family Members

*Spouse Name (First, MI, Last)

*Date of Birth (mm/dd/yyyy) *Social Security Number

Mailing Address (If different from above)

City State Zip

*Dependent(s) Name	*Relationship (ex. child)	*Social Security Number	*Date of Birth

Step 4: Employer Authorization

I hereby certify that the information contained above is accurate to the best of my knowledge. I understand that Discovery will not be held liable for missing or inaccurate information.

*Completed By: *Daytime Phone Number *Date: