WageWorks®

COBRA Account Status Update Request Form

Instructions for Form Completion

Complete, sign and return the COBRA Account Status Update Request Form to:

Toll-Free Fax: 877-220-3249

Mail To: COBRA Department
PO Box 14055
Lexington, KY 40512

Forms will be processed within 3-5 business days of receipt.

Request Types

Adding a New Dependent or Self to your COBRA Continuation Coverage

A dependent may only be added to coverage in the following circumstances: Marriage, Birth or Adoption. The dependent must be added within 30 days of the marriage, birth or adoption. Note that additional dependents will be added to your COBRA benefits effective the date of the qualifying event.

Removing a Dependent or Self from your COBRA Continuation Coverage

A dependent may be removed from coverage at any time with the signature of the dependent (if he/she is over age 18) or the signature of a parent/guardian (if the dependent is under age 18). Note that removal of dependents will be effective on the first day of the following month.

If the removal of a dependent is due to a death of the former employee, divorce or legal separation or a loss of dependent status, please clearly state this in the "Reason for the change" field as these events may attribute to an extension of the COBRA Continuation Coverage period.

Important Notes

- Adding or removing a dependent or self may change the tier level of coverage, which may include a change in premium rates.
- No documentation (birth certificate, adoption decree, divorce or legal separation decree) is needed for adding or removing a dependent or self from COBRA Continuation Coverage. However, the form must be completed and signed certifying the eligible change.

Voluntary Request to Terminate your COBRA Continuation Coverage

You may at any time request to voluntarily terminate your COBRA Continuation Coverage. However, please note that if payment for the given month has already been received and processed, COBRA Continuation Coverage will be terminated at the completion of that month. Otherwise COBRA Continuation Coverage will terminate as of the last day of the month in which a premium payment was made.

Medicare Entitlement

If at any point in time while on COBRA Continuation Coverage a Qualified Beneficiary becomes eligible and enrolled in Medicare, you must notify WageWorks of the entitlement to Medicare. Medical coverage on COBRA will then be terminated for the person who is on Medicare, however, they may continue to receive all other COBRA benefits (dental, vision etc.) up to the remainder of their maximum period. Other Qualified Beneficiaries that are not entitled to Medicare will continue to receive their medical coverage (and all other coverage) through COBRA Continuation Coverage up to the remainder of their maximum period.

Please refer to your original COBRA election packet for additional information regarding your rights as a qualified beneficiary. Any changes made on the form must comply with and adhere to the Consolidated Omnibus Reconciliation Act of 1986. Requests that do not comply will not be processed. For specific plan information, please see your Summary Plan Description (SPD). WageWorks does not process health claims. Claims should be directed to your respective carriers. Any health claims submitted with this form will be shredded upon receipt.

COBRA Account Status Update Request Form

TOLL-FREE FAX: 877-220-3249
OR, MAIL TO: COBRA Department, PO Box 14055, Lexington, KY 40512

Please refer to the Instruction Sheet for any questions on the completion of this form.
Complete all applicable sections of this form and submit to WageWorks based on the information indicated above.

PRIMARY QUALIFIED BENEFICIARY INFORMATION

☐ Check here if this is a new address

Last Name ________ First Name ________ Social Security # ________

Address ________ City ________ State ________ Zip ________

Program Sponsor (Former or Current Employer): ________ Email Address (complete only if new) ________

CERTIFICATION AND AUTHORIZATION

I certify that the information on this form is accurate and complete. I am requesting accurate changes to my account as listed below. Use of this service indicates my acceptance of the WageWorks User Agreement.

Signature of Primary Qualified Beneficiary X ________ Date: ________

REQUEST TYPE

ADD / REMOVE A DEPENDENT OR SELF

☐ **Add**
☐ **Remove**

Name ________ SSN ________ Effective Date ________ Date of Birth ________ Dependent Relationship ________

Reason for the Change ________

☐ Medical ☐ Dental ☐ Vision ☐ Other________

Dependent's Signature ________ Date ________

☐ **Add**
☐ **Remove**

Name ________ SSN ________ Effective Date ________ Date of Birth ________ Dependent Relationship ________

Reason for the Change ________

☐ Medical ☐ Dental ☐ Vision ☐ Other________

Dependent's Signature ________ Date ________

☐ **Add**
☐ **Remove**

Name ________ SSN ________ Effective Date ________ Date of Birth ________ Dependent Relationship ________

Reason for the Change ________

☐ Medical ☐ Dental ☐ Vision ☐ Other________

Dependent's Signature ________ Date ________

REQUEST TO TERMINATE COBRA CONTINUATION COVERAGE

(Termination requests made in this section automatically include all covered participants – if this is not your intention, please use the 'ADD/REMOVE A DEPENDENT OR SELF' section above.)

I request to terminate my COBRA Continuation Coverage effective: ________

☐ Terminate **ALL** my current COBRA benefits
☐ Terminate **only the listed** COBRA benefits: ________

MEDICARE ENTITLEMENT NOTIFICATION

The following individual has become covered by Medicare effective: ________

Member Name: ________

UPDATE / CORRECT NAME

Incorrect Name: ________ Correct Name: ________

UPDATE SOCIAL SECURITY NUMBER

Name of Member: ________

Old Social Security Number: ________ Updated Social Security Number: ________

UPDATE / CORRECT DATE OF BIRTH

Qualified Beneficiary or dependent: ________ Correct Date of Birth: ________

Please refer to your original COBRA election packet for additional information regarding your rights as a qualified beneficiary. Any changes made on this form must comply with and adhere to the Consolidated Omnibus Reconciliation Act of 1986. Requests that do not comply will not be processed. For specific plan information, please see your summary plan description (SPD). WageWorks does not process health claims. Claims should be directed to your respective carriers. Any health claims submitted with this form will be shredded upon receipt.

WW-COBRA-ACCT-CHANGE-LEXINGTON (Sep 2011)