FURTHER℠

VEBA ADD DEPENDENT FORM

Group Information

Group Name: _____ **Further Group Number**:_____

Location Name (if applicable):_____

Employee Information

SSN#:_____

Last Name:_____ **First Name**:_____ **Middle Initial**:_____

Dependents on a Group Sponsored Health Plan

Dependent SSN#	Name	DOB	Gender	Type of Dependent	Health Plan Effective Date

Are any of these dependents on Medicare?

☐ **Yes:** Enter the dependents below

☐ **No**

Dependent name:_____ **Medicare Effective Date:**_____

Dependent name:_____ **Medicare Effective Date:**_____

Dependent name:_____ **Medicare Effective Date:**_____

Employees: please return this form to your employer

Employers: after you have validated this information is correct, please select an option below to submit to Further.

Complete online:
Log into your account at hellofurther.com

Send via secured email only:
Further.Documents @hellofurther.com

Fax to:
866-231-0214

Mail to:
PO Box 982814
El Paso, TX 79998-2814