

Group Information

Group Name: _____ Further Group Number: _____

Location Name (if applicable): _____

Employee Information

SSN#: _____

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

Dependents on 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:
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El Paso, TX 79998-2814