FURTHER

HRA 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 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:
P.O. Box 64193
St. Paul, MN 55164-0193

X21461R01 (03/18)