FURTHER℠

VEBA ENROLLMENT FORM

Group Information

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

Location Name (if applicable): _____

Employee Information

SSN#: _____ **Primary Phone:** _____

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

Street Address: _____

City: _____ **State:** _____ **ZIP Code:** _____

Email Address: _____ **Date of Birth:** _____

Account Information

VEBA:

Effective Date: _____(to be provided by group contact)

Health Plan Coverage:

☐ **VEBA Active**

☐ **VEBA Post**
(Effective date is the last day of employment)

☐ **VEBA Wellness**

☐ **VEBA Retiree**
(Account is pre-funded and funds frozen)

Dependent on Health Plan

☐ **Single**

Does this dependent have Medicare?

☐ **Yes.** Medicare Effective Date:_____

☐ **No.**

☐ **Family Coverage** (if checked, fill out the VEBA dependent form)

Employer's Signature

Signature: _____ **Date:** _____

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