www.wexinc.com
Phone: 866-451-3399
Fax: 888-408-7224
PO Box 2926 · Fargo, ND 58108-2926
cobraforms@wexhealth.com

Open Enrollment Form

Please fill out this enrollment form and have it postmarked, faxed, or emailed no later than the end of the open enrollment period. Omitting any information may delay coverage changes with the carriers.

Section 1: Primary Participant's Information

Please provide the primary participant's information. Check elect to continue coverage or add a new plan. Check waive to decline or terminate existing coverage. Changes will be made as of the effective date in the packet.

Primary Participant Name (First, MI, Last) ___ Social Security Number ___ - ___ - ___ Date of Birth ___

Phone Number ___ Email ___

Elect/ Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___ Waive/ Terminate: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___

Section 2: Plan and Level of Coverage

Please specify the plan and level of coverage. Level of coverage examples: EE, EE + Spouse, EE + Child(ren), EE + Family, Child Only. Please refer to the enclosed information for the type of coverage available to you.

Medical Plan Name:		Medical Level of Coverage:	
Dental Plan Name:		Dental Level of Coverage:	
Vision Plan Name:		Vision Level of Coverage:	
Other Plan Name:		Other Plan Level of Coverage:	

Section 3: Dependent Information

Please provide spouse/dependent information. Check elect to continue coverage or add a new plan. Check waive to decline or terminate existing coverage. Changes will be made as of the effective date in the packet. To terminate coverage from a spouse, the spouse's signature is required in section 4. Please refer to the enclosed information for the type of coverage available to you.

Spouse Name (First, MI, Last) ___ Social Security Number ___ - ___ - ___ Date of Birth ___ Gender (M/F) ___

Elect/ Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___ Waive/ Terminate: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___

Dependent Name (First, MI, Last) ___ Social Security Number ___ - ___ - ___ Date of Birth ___ Gender (M/F) ___

Elect/ Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___ Waive/ Terminate: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___

Dependent Name (First, MI, Last) ___ Social Security Number ___ - ___ - ___ Date of Birth ___ Gender (M/F) ___

Elect/ Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___ Waive/ Terminate: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___

Dependent Name (First, MI, Last) ___ Social Security Number ___ - ___ - ___ Date of Birth ___ Gender (M/F) ___

Elect/ Continue: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___ Waive/ Terminate: ☐ Medical ☐ Dental ☐ Vision ☐ Other: ___

Section 4: Authorization

The information is complete and correct to the best of my knowledge. During the open enrollment period, I authorize WEX Health, Inc., a WEX Company to make changes to my benefits that are stated on this form. I understand that any changes postmarked, emailed or faxed after the open enrollment period will not be honored and therefore my benefits will stay at the current level or may terminate.

Primary Participation Signature ___ Date ___ Spouse Signature ___ Date ___

(Only required if coverage is being terminated for the spouse)