866-451-3399

VEBA Data Collection Worksheet

Please complete and submit this worksheet to your employer. **This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.**

Group Information

WEX Group Name:

Location Name (if applicable)

Participant Information

*Participant Name (First, MI, Last)

*Social Security Number

*Date of Birth (mm/dd/yyyy)

*Participant Mailing Address

*City

*State

*Zip

Email Address

Primary Telephone

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 Limited Combo (Dental, Vision, Post Deductibe Expenses)
- ☐ VEBA Retiree (Account is pre-funded and funds frozen)

Dependent on Health Plan

Check all that apply:

☐ **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