Carrier Eligibility Guide

WEX
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Phone: (877) 900-3390
Email: cobraupdates@wexhealth.com
Website: https://www.wexinc.com

5/14/2021

CARRIER NAME:
ATTN:
EMAIL:

CARRIER FAX:
CARRIER PHONE:
CARRIER ADDRESS:

Action Needed: Member Eligibility Updates

Please update the COBRA or Direct Bill Member Record with the following: ELECTION

Client Name: Sample Client
Client Division Name: Sample Division
EIN: 00-0000000

Member Name: Sally Sample
Member Type: Qualified Beneficiary
SSN: 888-88-8888
Individual ID: 8888
Member Address: 123 Sample Drive
Town, ND 00000

Gender: Female
DOB: 2/18/1980
Plan Name: Bronze Medical
Insurance Type: Medical
Carrier Plan ID: 224482
Notification Type: Reinstatement (Election)
Effective Date: 5/1/2021
First Day of Coverage 5/1/2021
Last Day of Coverage11/1/2022
Coverage Level: QB+Spouse

Carrier Sub codes: 012

Dependents:

Name: Tim Sample
Dependent Type: Spouse
SSN: 888-88-8888
Dependent Address: 123 Sample Drive
Town, ND 00000
Gender: Male
DOB: 05/18/1980

Coverage Level: QB+Spouse
First Day of Coverage: 5/1/2021
Last Day of Coverage: 11/1/2022

Will indicate if member is a Qualified Beneficiary or Direct Bill Member.

Qualified Beneficiary: Member's coverage subject to Federal COBRA regulations.

Direct Bill Member: Premium Payment arrangement through WEX. These members may be active employees, retirees, or on leave of absence.

The action we are asking you to take on this account. Please see below for an explanation of each notification type.

Notification Types

Reinstatement (election): The member has elected and paid for COBRA or Direct Bill. Please activate coverage for the member and any listed dependents.

Termination: The member has either stopped paying for coverage or has reached the end of their coverage eligibility period. Please terminate the coverage for the member and any listed dependents.

Dependent Termination: The member has dropped their dependent(s) from their plan. Please terminate only the dependents listed.

Plan Add: Enroll the member in the plan(s) that are indicated.

Coverage Level Change: The member has added or dropped dependents. Please update as indicated.

Dependent-Only Coverage Election: The dependent listed has elected and paid for their COBRA or Direct Bill. Please activate coverage for the dependent listed.

Dependent-Only Coverage Plan Add: Ensure the dependent(s) listed is covered under the indicated plan(s).

Dependent Termination: The member's dependents are no longer eligible for coverage or has reached the end of their COBRA or Direct Bill timeframe. Please terminate the coverage for the listed dependent(s).

Demographic Change: The member had a change to their personal demographic information. Please review your records and update DOB, SNN, Gender or name as needed.

Plan Delete: Remove the plan indicated.

Dependent-Only Coverage Plan Delete: Remove the dependent plan as indicated.

Disability Extension: The member was approved for an 11 month extension of their COBRA coverage period (for a total of 29 months) due to disability.