



Initial Client Information

Employer's Legal Name:			
Mailing Address:	City:	State:	Zip:
Street Address:	City:	State:	Zip:
Tax ID:	State Organized:		
Divisions:	Is Separate billing needed for divisions? <input type="checkbox"/> Yes* <input type="checkbox"/> No		
*If Yes - Divisional billing notes:			
Industry: (Ex. Bank or Retail)		EIN Number:	
Type of Company: (Circle One)	C-Corp.	S-Corp.*	Partnership Sole Prop. Non Profit Other:
<small>* A self-employed individual, partner or person who owns more than 2% of the outstanding stock is not eligible to enroll</small>			
Total Number of Employees:		Number of Benefit Eligible Employees:	
Primary Contact			
Primary Contact:		Title:	
E-Mail:	Telephone: ()	Fax: ()	
Broker			
Agency:		Broker:	
Copy Broker on all emails: <input type="checkbox"/> Yes <input type="checkbox"/> No		Notes for Contacting Client:	
E-Mail:	Telephone: ()	Fax: ()	
Address:	City:	State:	Zip:
Plan Information			
<input type="checkbox"/> COBRA <input type="checkbox"/> Commonwealth Health Connector <input type="checkbox"/> Commuter Choice (Parking & Transit) <input type="checkbox"/> Flexible Spending Accounts (FSA)		<input type="checkbox"/> Health Reimbursement Arrangement (HRA) <input type="checkbox"/> HIRD Tracking (Massachusetts Employers Only) <input type="checkbox"/> Premium Conversion Plan (POP) <input type="checkbox"/> Tuition Reimbursement	
Intended BSL Effective Date:		Fiscal Year End Date:	
Plan Year: (Ex. January 1 - December 31)			
<input type="checkbox"/> Short plan year (If short plan is FSA- Proration of Dependent Care election is required, Health Care is recommended)			
Plan Notes:			
<small>(please note here if plan start dates or effective dates are different for multiple plans)</small>			

COBRA Client Information

COBRA Contact:

Same as primary contact

Title:

E-Mail:

Telephone: ()

Fax: ()

Prior COBRA Administrator:

Current COBRA participants to Takeovers:

Non-Insured COBRA Eligible Plan

If a FSA is not offered or COBRA does not apply, enter N/A and skip to next section

FSA: Plan Administrator:

Point of Contact:

Email:

Telephone: ()

Fax: ()

Non-Insured COBRA Eligible Plan

If a HRA is not offered or COBRA does not apply, enter N/A and skip to next section

HRA: Plan Administrator:

Point of Contact:

Email:

Telephone: ()

Fax: ()

Is your HRA plan coupled with the medical plan?

Yes* No (HRA does not involve the medical plan)

*If yes, please list the name of the plan(s) involved with the HRA:

Are COBRA participants allowed to elect the medical plan without the HRA?

Yes No (Medical must include the HRA)

HRA Coverage Level	HRA Monthly Premium	Administration Fee (Benefit Strategies Retains)	HRA COBRA Rate (Including 2% Admin)
Employee (EE) Only	\$	+ 2% Administration Fee	=
EE & Spouse	\$	+ 2% Administration Fee	=
EE & Child	\$	+ 2% Administration Fee	=
EE & Children	\$	+ 2% Administration Fee	=
EE & Family	\$	+ 2% Administration Fee	=

Insured COBRA Eligible Plan

Includes Medical, Dental, Vision, and Employee Assistance Program (EAP)

Does your company provide a subsidy for COBRA coverage? Yes* No

Is the plan age rated? Yes* No

*If Yes, Please describe below AND provide separate rates including the subsidy on the Plan Information/Rates Section

COBRA Fees

Plan Installation & Open Enrollment	Current COBRA Participants Takeover	Initial Notice - New Hires	Qualifying Event Notice
\$	\$ /takeover	\$ /notice	\$ /notice
Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client	Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client	Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client	Who Pays <input type="checkbox"/> Broker <input type="checkbox"/> Client

Benefit Strategies, LLC Retains the 2% Administration Fee

Plan Notes:

Insured COBRA Eligible Plan Information (Please fill this form out for each insured COBRA eligible plan)

Carrier Name:	Plan Name:	Group #:	
Address:	City:	State: Zip:	
Carrier Enrollment Contact:			
Email:	Telephone: ()	Fax: ()	
Has this carrier been notified that Benefit Strategies is the Third Party Administrator? <input type="checkbox"/> Yes <input type="checkbox"/> No* *If No, please note that most carriers need written notification of Benefit Strategies before information can be shared.			
How would you prefer Benefit Strategies Reinstate or Terminate COBRA participants? <input type="checkbox"/> E-Mail Carrier Contact <input type="checkbox"/> Fax Carrier Contact <input type="checkbox"/> Online Access (Provide Benefit Strategies with access below)			
Web Address:	User ID:	Password:	
Plan Type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Employee Assistance Program (EAP) <input type="checkbox"/> Other:			
When is the next plan renewal date? / /	What state governs this plan?		
What is the waiting period for this plan?	Does plan allow for conversion? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Is this a new or existing plan? <input type="checkbox"/> Existing <input type="checkbox"/> New	Is plan Self Funded? <input type="checkbox"/> Yes <input type="checkbox"/> No	At what age does dependent status end?	
When does active employee coverage end after a COBRA Qualifying Event (QE)? <input type="checkbox"/> On QE Date <input type="checkbox"/> At End of QE month	When does COBRA coverage end after a COBRA expires? <input type="checkbox"/> Exactly 18 months from Event <input type="checkbox"/> At End of month		
Coverage Level	Monthly Premium	Administration Fee	COBRA Rate (Including 2%)
Employee (EE) Only	\$	+ 2% Administration Fee	=
EE & Spouse	\$	+ 2% Administration Fee	=
EE & Child or Children (Circle One)	\$	+ 2% Administration Fee	=
EE & Family	\$	+ 2% Administration Fee	=

Insured COBRA Eligible Plan Information (Please fill this form out for each insured COBRA eligible plan)

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