

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 #: _____ Sub-Loc # (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Carrier Enrollment Contact:

Email: _____ Telephone: () _____ Fax: () _____

Has this carrier been notified that Benefit Strategies is the Third Party Administrator? Yes 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?
 E-Mail Carrier Contact Fax Carrier Contact Online Access (Provide Benefit Strategies with access below)

Web Address: _____ User ID: _____ Password: _____

Plan Type: Medical Dental Vision Employee Assistance Program (EAP) 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? Yes No

Is this plan linked or bundled with another health plan? No Yes, please list:

Is this a new or existing plan? Existing New Is plan Self Funded? Yes No At what age does dependent status end? _____

Coverage Level	Monthly Premium	Administration Fee	COBRA Rate (Including 2%)
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 Information (Please fill this form out for each insured COBRA eligible plan)

Carrier Name: _____ Plan Name: _____

Group #: _____ Sub-Loc # (if applicable): _____

Address: _____ City: _____ State: _____ Zip: _____

Carrier Enrollment Contact:

Email: _____ Telephone: () _____ Fax: () _____

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EE & Child	\$	+ 2% Administration Fee	=
EE & Children	\$	+ 2% Administration Fee	=
EE & Family	\$	+ 2% Administration Fee	=

Please copy this form to provide information on additional plans