

# My COBRA Resource COBRA Administration and Compliance Solutions CLIENT INFORMATION FORM

CLIENT PROFILE										
Client Legal Name:				Tax Id #						
Mailing Address:										
City:	Zip Code:									
SYSTEM/EMAIL CONTACT INFORMATION										
	Select all that apply	Allow COBRA System Access	Add Contact to All Client Emails	Email Remittance Report Reminder	Email Carrier Notifications (If not done by ABG)	Include in COBRA Renewal/OE Emails				
Primary Contact:  Email:	Title:									
Other Contact: Email:	Title:									
Other Contact:  Email:	Title:									
Other Contact: Email:	Title:									
Other Contact: Email:	Title:									
Other Contact: Email:	Title:									
Other Contact:  Email:	Title:									
Broker Contact: Email:	Title:									
				1						
Information Provided By:				Date:						

## SET UP QUESTIONNAIRE & OTHER SERVICES

CURRENT COBRA PARTICIPANT INFORMATION								
Are there any COBRA participants – either actively enrolled or in the 60-day election window?	Yes – provide their information on the COBRA Member Gathering Form	□No						
OPEN EN	IROLLMENT							
Is the group in Open Enrollment?	Yes	□No						
If yes, have COBRA participants already been notified	Yes – Date COBRA OE ends:	□No						
If the rates for any plans renewed in the last 60 days, the rates must	be provided for <u>both</u> plan years. You may du	uplicate this form as needed.						
BUNDL	ED PLANS							
Are any plans (other than an HRA/Medical) bundled together? (For HRAs see page 7)	Yes – list plans:	□No						
STATE CONTINUATION  (ABG's COBRA Portal is optimized for Federal COBRA Administration. ABG is able to administer state extensions in addition to Federal COBRA for fully insured plans issued in NY, TX & CT. ABG does <u>not</u> administer CAL-COBRA. If this group needs state continuation only, mini-COBRA administration, or another continuation rule other than those outlined above, please discuss this with us prior to submitting the form)								
Is state continuation applicable for this group?	Yes – State:	□No						
If yes, who will be responsible for the state continuation?	Client	☐ ABG						
If ABG, will participants automatically be granted the extension or required to submit an additional form?	☐ Election Form Required	☐ Automatic Extension						
Additional Services (must also be Please note that if selected these services are set up separately will be sent when these additional services are live and until the		account. A separate email						
CARRIER N	OTIFICATIONS							
Did you select on the Agreement for ABG to handle the COBRA eligibility changes ('carrier notifications')?	☐ YES (see below)	No — carrier notifications will go to the contacts indicated on page 1						
	Please double check/confirm this wa	as selected on the Agreement						
If yes:								
EDI FILES								
Will you be sending EDI Files?	Yes	□No						
(includes EmployeeNavigator & EASE)  If yes, Who Will Be Sending EDI Files?								
Contact Name:								
Contact Email:								
Contact Tel#:								

## PLAN INFORMATION

ME	EDICAL/RX F	PLAN #1		MEDICAL/RX PLAN #2					
Carrier Name:					Carrier Name:				
Plan Name: (HMO, PPO	)			Plan Name: (HMO, PP	0)				
Plan or Group #				Plan or Group #					
Effective date:	En	d Date:		Effective date:	Eı	nd Date:			
Select one:  Fully Ins	ured 🗌 Se	elf Insured		Select one: Tully Ir	sured Se	elf Insured			
Conversion Option: (When Federal COBRA health plan into an in carrier if unsure if the	A ends, can pa dividual policy	with the carri		Conversion Option: Yes No (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option)					
RATES	/PREMIUM	AMOUNTS		RATE	s/premium	AMOUNTS			
RATE BASED ON CO	VERAGE LEVEL	L: COMPOSITE		RATE BASED ON C	OVERAGE LEVE	L: COMPOSITE			
Please provide rate for TIER NAME:	-	f the rate is the s		Please <i>provide rate</i> TIER NAME:		f the rate is the s			
Member Only				Member Only					
Member + Spouse				Member + Spouse					
Member + 1 Child				Member + 1 Child	- <del></del>	<del></del>			
Member + Children				Member + Childre	n	<del></del>			
Member + Family				Member + Family					
Age Banded Rates* section below and attaction below and attaction.	h a CSV/Excel			Age Banded Rates section below and atto The plan cannot be bu	ach a CSV/Excel				
*Age Determined B	y:			*Age Determined	Ву:				
☐ Birthday – rate o	changes 1st of	the month foll	owing birthday	☐ Birthday – rate	changes 1st of	the month foll	owing birthday		
☐ Birthday as of Pl age at time of		tart – rate cha	nges based on	☐ Birthday as of age at time		tart – rate cha	nges based on		
TE	RMINATION	N RULES		Т	ERMINATION	N RULES			
Event Type	EOM	DOE	OTHER*	Event Type	EOM	DOE	OTHER*		
Termination/	П	П	П	Termination/					
Reduction in Hours  The termination rule ab  events yes no –				Reduction in Hours  The termination rule a  events ☐ yes ☐ no					
Divorce				Divorce					
Ineligible Dependent				Ineligible Dependent					
Death of Employee				Death of Employee					
*please specify		·	<del></del>	*please specify:					

# THE MONTHLY PREMIUM RATES ARE THE CARRIER COSTS WITHOUT THE 2% COBRA ADMINISTRATION FEE ALL INFORMATION MUST BE FILLED OUT IN ORDER TO SET UP THE ACCOUNT

M	EDICAL/RX F	PLAN #3		ME	EDICAL/RX I	PLAN #4			
Carrier Name				Carrier Name					
Carrier Name: Plan Name: (HMO, PPO)					Carrier Name: Plan Name: (HMO, PPO)				
Plan or Group #				Plan or Group #					
Effective date:				Effective date:					
Select one: Fully Ins				Select one: Fully Inst					
Conversion Option:  (When Federal COBR health plan into an ir carrier if unsure if the	Yes No A ends, can pa	articipants conv		Conversion Option: Yes No (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option)					
RATES	S/PREMIUM	AMOUNTS		RATES	/PREMIUM	AMOUNTS			
RATE BASED ON CO	VERAGE LEVEL	.: COMPOSITE		RATE BASED ON CO	VERAGE LEVE	L: COMPOSITE			
Please provide rate for <b>TIER NAME:</b>		f the rate is the s		Please provide rate fo		f the rate is the s			
Member Only				Member Only					
Member + Spouse				Member + Spouse		<del></del>			
Member + 1 Child				Member + 1 Child					
Member + Children		<del></del>		Member + Children	<del></del>	<del></del>			
Member + Family				Member + Family		<del></del>			
Age Banded Rates* section below and attace The plan cannot be buil	ch a CSV/Excel			Age Banded Rates* - section below and attac	h a CSV/Excel				
*Age Determined B	y:			*Age Determined By	<b>/</b> :				
☐ Birthday – rate o	changes 1st of	the month foll	owing birthday	☐ Birthday – rate o	hanges 1st of	the month foll	owing birthday		
Birthday as of Pl		tart – rate cha	nges based on	☐ Birthday as of Planage at time of		tart – rate cha	nges based on		
TE	RMINATION	N RULES		TE	RMINATION	N RULES			
Event Type	EOM	DOE	OTHER	Event Type	EOM	DOE	OTHER		
Termination/ Reduction in Hours  The termination rule ab  events  yes  no —				Termination/ Reduction in Hours  The termination rule above events yes no –					
Divorce				Divorce					
Ineligible Dependent				Ineligible Dependent					
Death of Employee				Death of Employee					
*please specify:				*please specify:					

# THE MONTHLY PREMIUM RATES ARE THE CARRIER COSTS WITHOUT THE 2% COBRA ADMINISTRATION FEE ALL INFORMATION MUST BE FILLED OUT IN ORDER TO SET UP THE ACCOUNT

DENTAL PLAN # 1				DENTAL PLAN # 2				
Carrier Name:			Carrier Name:					
Plan Name: (HMO, PPO	))			Plan Name: (HMO, PPO	)			
Plan or Group #				Plan or Group #				
Effective date:	End	d Date:		Effective date:	En	ıd Date:		
Select one: Tully Ins	sured Se	lf Insured		Select one: Tully Ins	sured Se	elf Insured		
Conversion Option: Yes No (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option)				Conversion Option: Yes No (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option)				
RATES	S/PREMIUM	AMOUNTS		RATES	S/PREMIUM	AMOUNTS		
RATE BASED ON CO				RATE BASED ON CO				
Please provide rate for <b>TIER NAME:</b>		the rate is the s		Please provide rate for TIER NAME:		if the rate is the s HLY PREMIUM		
Member Only				Member Only		<del></del>		
Member + Spouse				Member + Spouse	Member + Spouse			
Member + 1 Child				Member + 1 Child				
Member + Children	<u> </u>			Member + Children	Member + Children			
Member + Family				Member + Family		<del></del>		
TE	ERMINATION	RULES		TE	RMINATION	N RULES		
		5.05	0.7115.04	Frank Tring	FOM	DOL	OTUED*	
Event Type	EOM	DOE	OTHER*	Event Type	EOM	DOE	OTHER*	
Termination/ Reduction in Hours			Ш	Termination/ Reduction in Hours		Ш		
The termination rule ab events ☐ yes ☐ <b>no</b> —				The termination rule ab		-		
Divorce				Divorce				
Ineligible Dependent				Ineligible Dependent				
Death of Employee				Death of Employee				
*please specify:				*please specify:				

# THE MONTHLY PREMIUM RATES ARE THE CARRIER COSTS WITHOUT THE 2% COBRA ADMINISTRATION FEE ALL INFORMATION MUST BE FILLED OUT IN ORDER TO SET UP THE ACCOUNT

VISION PLAN # 1				VISION PLAN # 2					
Carrier Name:				Carrier Name:					
Plan Name: (HMO, PPO	0)			Plan Name: (HMO, PPO	D)				
Plan or Group #				Plan or Group #					
Effective date:	End	d Date:		Effective date:	Effective date:End Date:				
Select one:  Fully In	nsured Sel	f Insured		Select one:  Fully In	Select one: Fully Insured Self Insured				
Conversion Option: Yes No (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option)				(When Federal COBI health plan into an i	Conversion Option: Yes No (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option)				
RATE	S/PREMIUM	AMOUNTS		RATE	RATES/PREMIUM AMOUNTS				
RATE BASED ON CO	for all tiers even if			RATE BASED ON CO	for all tiers even i				
Member Only	WONT	ET TIVEIVITOTAL	IVATES.		MONT	TLT PREIVIIOIVI	KATES:		
Member + Spouse	<del></del>			Member Only		<del></del>			
Member + 1 Child				Member + Spouse		<del></del>			
Member + Childre		<del></del>		Member + 1 Child		<del></del>			
	П			Member + Children					
Member + Family		<del></del>		Member + Family					
Т	ERMINATION	RULES		TI	TERMINATION RULES				
Event Type	EOM	DOE	OTHER*	Event Type	EOM	DOE	OTHER*		
Termination/ Reduction in Hours				Termination/ Reduction in Hours					
The termination rule a events yes no-	, ,	,	1 37 3	The termination rule a events  yes  no-					
Divorce				Divorce					
Ineligible Dependent				Ineligible Dependent					
Death of Employee				Death of Employee					
*please specify:				*please specify:			·		

## THE MONTHLY PREMIUM RATES ARE THE CARRIER COSTS WITHOUT THE 2% COBRA ADMINISTRATION FEE

#### HEALTH REIMBURSEMENT ACCOUNT (HRA) #1 HEALTH REIMBURSEMENT ACCOUNT (HRA) #2 Carrier Name: \_\_\_\_\_ Carrier Name: Plan or Group # Plan or Group # Effective date: \_\_\_\_\_End Date: \_\_\_\_ Effective date: \_\_\_\_\_End Date: \_\_\_\_ Which health plan is the HRA linked to: Which health plan is the HRA linked to: How will the HRA be offered on COBRA? How will the HRA be offered on COBRA? Bundled – when members elect the medical plan, they Bundled – when members elect the medical plan, they automatically receive the HRA on COBRA. automatically receive the HRA on COBRA. Offered Separately – Members can enroll in the medical Offered Separately – Members can enroll in the medical only, or the medical and HRA. (Never the HRA alone) only, or the medical and HRA. (Never the HRA alone) Do the medical plan rates on the previous page include the HRA Do the medical plan rates on the previous page include the HRA amount already? amount already? YES YES NO – the rates below need to be factored in NO – the rates below need to be factored in **RATES/PREMIUM AMOUNTS RATES/PREMIUM AMOUNTS** Please note: ABG COBRA cannot calculate your COBRA rate. If Please note: ABG COBRA cannot calculate your COBRA rate. If unsure, contact your HRA Administrator. If that is ABG, you can unsure, contact your HRA Administrator. If that is ABG, you can review additional information here: HRAs & COBRA review additional information here: HRAs & COBRA First year HRAs can use the following formula to determine the First year HRAs can use the following formula to determine the rate: Total Amt of Benefit x .73 divided by 12 = monthly premium rate: Total Amt of Benefit x .73 divided by 12 = monthly premium TIER NAME: MONTHLY PREMIUM RATES: TIER NAME: MONTHLY PREMIUM RATES: Member Only Member Only Member + 1 Member + 1 Member + Family Member + Family ☐ Flat Rate ☐ Flat Rate Other(please explain) Other(please explain) **TERMINATION RULES TERMINATION RULES Event Type** EOM DOE OTHER\* **Event Type** EOM DOE OTHER\* $\Box$ П П П Termination/ Termination/ Reduction in Hours Reduction in Hours The termination rule above also applies for all other qualifying The termination rule above also applies for all other qualifying events yes no – please complete section below if no events yes no – please complete section below if no Divorce Divorce Ineligible Dependent Ineligible Dependent П Death of Employee Death of Employee \*please specify: \_\_\_\_\_ \*please specify:

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### MEDICAL FLEXIBLE SPENDING ACCOUNT (FSA) **ADDITIONAL PLAN** Plan Type: RX Only EAP Other Carrier Name: Plan or Group # Carrier Name: Plan Name: (HMO, PPO) Plan Year Start Date: \_\_\_\_\_ Plan or Group # Plan Year End Date: Select one: Fully Insured Self Insured Conversion Option: Yes No **RATES/PREMIUM AMOUNTS** (When Federal COBRA ends, can participants convert the group health plan into an individual policy with the carrier? Check with carrier if unsure if there is a conversion option) The ABG COBRA Portal will be set up to allow you to manually enter the monthly rate for each participant individually, based on their annual election. If you will have a file feed, this **RATES/PREMIUM AMOUNTS** information can come over on the file. ☐ RATE BASED ON COVERAGE LEVEL: COMPOSITE **TERMINATION RULES** Please provide rate for all tiers even if the rate is the same for some) TIER NAME: **MONTHLY PREMIUM RATES:** The ABG COBRA Portal will be set up to automatically offer the Member Only FSA for the day after the qualifying event in line with IRS rules. Member + Spouse If your FSA terminates at the end of the month, please notify us during implementation. Member + 1 Child Member + Children Member + Family Age Banded Rates\* – Please complete the "Age Determined by" section below and attach a CSV/Excel spreadsheet with the rates. The plan cannot be built without this. \*Age Determined By: ☐ Birthday – rate changes 1<sup>st</sup> of the month following birthday Birthday as of Plan Premium Start – rate changes based on age at time of renewal **TERMINATION RULES Event Type** EOM DOE OTHER\* Termination/ $\Box$ П Reduction in Hours The termination rule above also applies for all other qualifying events yes no – please complete section below if no Divorce Ineligible Dependent Death of Employee \*please specify: \_\_\_\_\_

Need more space for additional plans? Add additional plans on the <u>Plan Information Form</u> and submit with this setup form.

#### **CARRIER INFORMATION FORM**

This form is only required if ABG will handle the COBRA carrier notifications on your behalf. If the client/broker will be handling the COBRA carrier notifications, you may skip this page. Step 1 – Confirm this additional service is selected on your agreement Step 2 – Notify your carriers that ABG will be your new COBRA TPA & is authorized to act on your behalf to process COBRA enrollment changes. (Carriers may require an additional form to be completed as well) Invoices should not be sent to ABG. Step 3 – Complete the information below for each carrier & return to ABG Step 4 – ABG will reach out to each contact below to establish a clear process of ABG processing changes with them. Until this process is finalized all changes will be emailed to the client/broker to process. Step 5 – ABG will send a separate email when the setup of this additional service is completed and we will begin notifying carriers on your behalf. Client Name: Date: Benefit Type: Medical Dental Vision Other Carrier: Contact Name: Email: Tel: Date Authorization Sent to Carrier: Benefit Type: Medical Dental Vision Other Carrier: Contact Name: Email: Tel: Date Authorization Sent to Carrier: Benefit Type: Medical Dental Vision Other Carrier: Contact Name: Email: Tel: Date Authorization Sent to Carrier: Benefit Type: Medical Dental Vision Other Carrier: Contact Name: Email: Tel: Date Authorization Sent to Carrier:

NEED MORE SPACE? Download another copy of this form HERE and submit both together.