AMERICAN BENEFITS GROUP

My COBRA Resource

COBRA Administration and Compliance Solutions

CLIENT INFORMATION FORM

CLIENT PROFILE

Client Legal Name:		Tax Id #
Mailing Address:		
City:	State:	Zip Code:

Invoices are Emailed on a Monthly Basis
Please Designate Two Contacts

Name:	Email:	Tel:
Name:	Email:	Tel:

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
Primary Contact:	Title:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Email:	Tel:	☐ No	☐ No	☐ No	☐ No
Other Contact:	Title:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Email:	Tel:	☐ No	☐ No	☐ No	☐ No
Other Contact:	Title:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Email:	Tel:	☐ No	☐ No	☐ No	☐ No
Other Contact:	Title:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Email:	Tel:	☐ No	☐ No	☐ No	☐ No
Other Contact:	Title:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Email:	Tel:	☐ No	☐ No	☐ No	☐ No
Broker Contact:	Title:	☐ Yes	☐ Yes	☐ Yes	☐ Yes
Email:	Tel:	☐ No	☐ No	☐ No	☐ No

Information Provided By:	Signature:	Date:

SET UP QUESTIONNAIRE & OTHER SERVICES

Is Group in Open Enrollment?	☐ Yes – Date OE ends: _____	☐ No

If Yes, Duplicate and fill out Plan Information Form for Prior/Current Plan Year and New Plan Year

Total Number of **Benefit Eligible** Employees	
Total Number of Active **Employees Enrolled** in Benefits (Please provide Census on Active Employees tab of Member Gathering Spreadsheet)	
# of Active **COBRA** Members – List on QB Tab of Member Gathering Form	
# of Pending **COBRA** Members – List on QB Tab of Member Gathering Form	

Who Will Notify Carrier of COBRA Reinstatements and Terminations? – (*if ABG- please make sure this service is selected on the Service Agreement and complete the Carrier Information Form on page 10 of this packet)*	☐ ABG	☐ Client	☐ Broker

State Continuation, if Applicable is Handled By	☐ Client	☐ ABG
State Continuation, if Applicable – (confirm details with Carrier)	☐ Election Form Required	☐ Automatic Extension
If Using Divisions – Are Plans Assigned by Division?	☐ Yes*	☐ No
**If yes, please list divisions and plan structure on Divisions tab of Member Gathering Form*		

Are Any Plans Bundled Together? (HRA & Medical/Medical & Dental)	☐ Yes (List Plans Below)	☐ No

For the Qualifying Events Listed Below, When do Benefits Terminate?		
Divorce/Legal Separation	☐ End of Month	☐ Date of Event
Ineligible Dependent	☐ End of Month	☐ Date of Event
Death of Employee	☐ End of Month	☐ Date of Event

Will you be sending EDI Files?	☐ Yes	☐ No
If Applicable, Who Will Be Sending EDI Files?	☐ Vendor	☐ Group
If Vendor, Name of Vendor:		
**Contact Name:		
Contact Email:		
Contact Tel#:		
**** Please have your vendor contact our IT Department – imichael@amben.com– for file specifications and file testing**		

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

PLAN INFORMATION

Medical/Prescription Drug Benefit

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

OR

☐ Age of Employee with Coverage Levels* (attach/submit Excel spreadsheet)

☐ Age of Employee/Spouse & # of Children* (attach/submit Excel spreadsheet)

☐ ACA Rates*-Age of Employee/Spouse, Adult Children, # of Children – (attach/submit Excel spreadsheet)

***Age Determined By:**

☐ Birthday – rate changes 1st of the month following birthday

☐ Birthday as of Plan Premium Start – rate changes based on age at time of renewal

Date Termination of Coverage Becomes Effective:

☐ End of Month

☐ Date of Termination/Date of COBRA Event

☐ Wash/Roll-31st of previous month if term 1/-15

Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Medical/Prescription Drug Benefit

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

OR

☐ Age of Employee with Coverage Levels* (attach/submit Excel spreadsheet)

☐ Age of Employee/Spouse & # of Children* (attach/submit Excel spreadsheet)

☐ ACA Rates*-Age of Employee/Spouse, Adult Children, # of Children – (attach/submit Excel spreadsheet)

***Age Determined By:**

☐ Birthday – rate changes 1st of the month following birthday

☐ Birthday as of Plan Premium Start – rate changes based on age at time of renewal

Date Termination of Coverage Becomes Effective:

☐ End of Month

☐ Date of Termination/Date of COBRA Event

☐ Wash/Roll-31st of previous month if term 1/-15

Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

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

Medical/Prescription Drug Benefit

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

OR

☐ Age of Employee with Coverage Levels* (attach/submit Excel spreadsheet)

☐ Age of Employee/Spouse & # of Children* (attach/submit Excel spreadsheet)

☐ ACA Rates*-Age of Employee/Spouse, Adult Children, # of Children – (attach/submit Excel spreadsheet)

***Age Determined By:**

☐ Birthday – rate changes 1st of the month following birthday

☐ Birthday as of Plan Premium Start – rate changes based on age at time of renewal

Date Termination of Coverage Becomes Effective:

☐ End of Month

☐ Date of Termination/Date of COBRA Event

☐ Wash/Roll-31st of previous month if term 1/-15

Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Vision Benefit

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

Date Termination of Coverage Becomes Effective:

☐ End of Month

☐ Date of Termination/Date of COBRA Event

☐ Wash/Roll-31st of previous month if term 1/-15

Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

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 Benefit

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

Date Termination of Coverage Becomes Effective:

- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ Wash/Roll-31st of previous month if term 1/-15

  Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Dental Benefit

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

Date Termination of Coverage Becomes Effective:

- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ Wash/Roll-31st of previous month if term 1/-15

  Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

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

Health Reimbursement Account (HRA) Benefit

Plan Year Start Date _____

Plan Year End Date _____

Is this HRA linked to a Health Plan? ☐ Yes ☐ No

If yes; Name of Health Plan _____

Are the rates bundled with the medical plan? ☐ Yes ☐ No

***Please note*: 1st year HRA plan rates are calculated as listed below unless noted otherwise by Employer**

Total Amt of Benefit x .73 divided by 12 = monthly premium

TIER NAME:	MONTHLY PREMIUM RATES:
Individual Only	_____
Individual + 1	_____
Individual + Family	_____
Flat Rate	_____
Other	(attach copy of rates)

Date Termination of Coverage Becomes Effective:

☐ End of Month
☐ Date of Termination/Date of COBRA Event
☐ 15th or 31st (WashRoll Rule)

ADMINISTRATOR'S INFORMATION:

Plan Administrator _____

Plan Name _____

Plan or Group # _____

Health Reimbursement Account (HRA) Benefit

Plan Year Start Date _____

Plan Year End Date _____

Is this HRA linked to a Health Plan? ☐ Yes ☐ No

If yes; Name of Health Plan _____

Are the rates bundled with the medical plan? ☐ Yes ☐ No

***Please note*: 1st year HRA plan rates are calculated as listed below unless noted otherwise by Employer**

Total Amt of Benefit x .73 divided by 12 = monthly premium

TIER NAME:	MONTHLY PREMIUM RATES:
Individual Only	_____
Individual + 1	_____
Individual + Family	_____
Flat Rate	_____
Other	(attach copy of rates)

Date Termination of Coverage Becomes Effective:

☐ End of Month
☐ Date of Termination/Date of COBRA Event
☐ 15th or 31st (WashRoll Rule)

ADMINISTRATOR'S INFORMATION:

Plan Administrator _____

Plan Name _____

Plan or Group # _____

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

Health FSA Benefit (Cafeteria Plan Year)

Plan Year Start Date _____

Plan Year End Date _____

ADMINISTRATOR'S INFORMATION:

Plan Administrator _____

Plan Name _____

Plan or Group # _____

Other Benefit

Description _____

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

OR

☐ Age of Employee with Coverage Levels* (attach/submit Excel spreadsheet)

☐ Age of Employee/Spouse & # of Children* (attach/submit Excel spreadsheet)

☐ ACA Rates*-Age of Employee/Spouse, Adult Children, # of Children – (attach/submit Excel spreadsheet)

***Age Determined By:**

☐ Birthday – rate changes 1st of the month following birthday

☐ Birthday as of Plan Premium Start – rate changes based on age at time of renewal

Date Termination of Coverage Becomes Effective:

☐ End of Month

☐ Date of Termination/Date of COBRA Event

☐ Wash/Roll-31st of previous month if term 1/-15

Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

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

Other Benefit

Description _____

Effective _____ **End Date** _____

RATE BASED ON COVERAGE LEVEL: COMPOSITE

(Please provide rate for all tiers even if rate is the same)

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
Member + 1 Child	_____
Member + Children	_____
Member + Family	_____

OR

☐ Age of Employee with Coverage Levels* (attach/submit Excel spreadsheet)

☐ Age of Employee/Spouse & # of Children* (attach/submit Excel spreadsheet)

☐ Member Specific Rate

☐ ACA Rates*-Age of Employee/Spouse, Adult Children, # of Children – (attach/submit Excel spreadsheet)

***Age Determined By:**

☐ Birthday – rate changes 1st of the month following birthday

☐ Birthday as of Plan Premium Start – rate changes based on age at time of renewal

Date Termination of Coverage Becomes Effective:

☐ End of Month

☐ Date of Termination/Date of COBRA Event

☐ Wash/Roll-31st of previous month if term 1/-15

Or 1st of next month if term 16th-31st

Insured Type: ☐ Fully ☐ Self

Does the Plan Offer to Convert to Individual Plan At the End of COBRA? ☐ Yes ☐ No

CARRIER INFORMATION:

Carrier Name _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

COBRA Eligible Benefits Include:

- Medical Plans
- Dental Plans
- Vision Plans
- Employee Assistance Plans
- Flexible Spending Accounts (FSA)
- Health Reimbursement Account (HRA)
- Discount Programs
- Disease-specific policies that provide medical treatments (e.g., cancer)
- Some Wellness Programs
- Prescription Drug Plans
- Hearing care
- Treatment programs and clinics maintained by the employer (except first aid care provided free of charge to employees during working hours)

Please Note: HSAs – Health Savings Accounts and Dependent Care are not COBRA eligible plans.

COBRA DIRECT DEPOSIT AUTHORIZATION FORM

This authorizes American Benefits Group to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to the account indicated below. This authorizes the financial institution holding the account to post all such entries. We agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law.

The company agrees to monthly verify the funds deposited agree to the **monthly COBRA Remittance report minus the monthly Refund report** that is posted to the COBRA system and to notify American Benefits Groups of any discrepancies.

This authorization is to remain in effect until American Benefits Group has received written notification from an authorized representative of the company.

REQUEST		
ADD Authorization	**CANCEL** Authorization* Effective:	**CHANGE** Authorization* Effective:

*When cancelling or changing your account information, please note we need to receive form at least 15 days prior to the 10th of the month of your request.

BANK ACCOUNT INFORMATION	
Client name	
Account #	
Account type	☐ Checking ☐ Savings ☐ General Ledger
Bank routing number	

AUTHORIZATION	
Authorized signature	
Print name	
Title	
Email	
Date	

Please return completed form to: American Benefits Group
PO Box 1209
Northampton, Ma 01061-1209
Fax: 413-584-2561 – Email: cobrasupport@amben.com

DO NOT WRITE BELOW THIS LINE –ABG Use Only	
Completed By	
Date	

CARRIER INFORMATION FORM

If the Carrier Notification option is selected on the COBRA Service Agreement, American Benefits Group will act on your behalf to contact carriers of COBRA terminations, reinstatements, address & plan changes.

<u>If the service is selected</u>, please fill out and notify carriers to authorize American Benefits to act on your behalf and allow online access to your account(s)

Client Name:	Date:

Benefit Type: ☐ Medical ☐ Dental ☐ Vision ☐ Other ________________	
Carrier:	Date Authorization Sent to Carrier:
Contact Name:	Email:
Tel:	

Benefit Type: ☐ Medical ☐ Dental ☐ Vision ☐ Other ________________	
Carrier:	Date Authorization Sent to Carrier:
Contact Name:	Email:
Tel:	

Benefit Type: ☐ Medical ☐ Dental ☐ Vision ☐ Other ________________	
Carrier:	Date Authorization Sent to Carrier:
Contact Name:	Email:
Tel:	

Benefit Type: ☐ Medical ☐ Dental ☐ Vision ☐ Other ________________	
Carrier:	Date Authorization Sent to Carrier:
Contact Name:	Email:
Tel:	

DO NOT WRITE BELOW THIS LINE – ABG Use Only		
Carrier:	Date Sent:	Date Access Received:
Carrier:	Date Sent:	Date Access Received:
Carrier:	Date Sent:	Date Access Received:
Carrier:	Date Sent:	Date Access Received: