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:

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:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Other Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Other Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Other Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Other Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Other Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Other Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					
Broker Contact:	Title:	☐	☐	☐	☐	☐
Email:	Tel:					

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 ENROLLMENT		
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 **both** plan years. You may duplicate this form as needed.*		
BUNDLED 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 **not** 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 selected on the Service Agreement) *Please note that if selected these services are set up separately from the implementation of your base account. A separate email will be sent when these additional services are live and until then are the responsibility of the client/broker to handle manually.*		
CARRIER NOTIFICATIONS		
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
If yes:	☐ Please double check/confirm this was selected on the Agreement	
	☐ Complete page 10 of this packet ("Carrier Information Form")	
EDI FILES		
Will you be sending EDI Files? (includes EmployeeNavigator & EASE)	☐ Yes	☐ No
If yes, Who Will Be Sending EDI Files?		
Contact Name:		
Contact Email:		
Contact Tel#:		

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/RX PLAN #1

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
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 1st 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/ 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* _____

MEDICAL/RX PLAN #2

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____ End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
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 1st 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/ 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:* _____

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/RX PLAN #3

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
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 1st 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/ 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:* _____

MEDICAL/RX PLAN #4

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
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 1st 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/ 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:* _____

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

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

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

TERMINATION RULES

Event Type	EOM	DOE	OTHER*
Termination/ 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:* _____

DENTAL PLAN # 2

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

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

TERMINATION RULES

Event Type	EOM	DOE	OTHER*
Termination/ 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:* _____

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

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

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

TERMINATION RULES

Event Type	EOM	DOE	OTHER*
Termination/ 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:* _____

VISION PLAN # 2

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

Effective date: _____End Date: _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

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

TERMINATION RULES

Event Type	EOM	DOE	OTHER*
Termination/ 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:* _____

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) #1

Carrier Name: _____

Plan or Group # _____

Effective date: _____End Date: _____

Which health plan is the HRA linked to:_____

How will the HRA be offered on COBRA?

- ☐ Bundled – when members elect the medical plan, they automatically receive the HRA on COBRA.
- ☐ Offered Separately – Members can enroll in the medical only, or the medical and HRA. (Never the HRA alone)

Do the medical plan rates on the previous page include the HRA amount already?

- ☐ YES
- ☐ NO – the rates below need to be factored in

RATES/PREMIUM AMOUNTS

Please note: ABG COBRA cannot calculate your COBRA rate. If unsure, contact your HRA Administrator. If that is ABG, you can review additional information here: HRAs & COBRA

First year HRAs can use the following formula to determine the rate: *Total Amt of Benefit x .73 divided by 12 = monthly premium*

TIER NAME:	MONTHLY PREMIUM RATES:
☐ Member Only	_____
☐ Member + 1	_____
☐ Member + Family	_____
☐ Flat Rate	_____
☐ Other(please explain)	_____

TERMINATION RULES

Event Type	EOM	DOE	OTHER*
Termination/ 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:* _____

HEALTH REIMBURSEMENT ACCOUNT (HRA) #2

Carrier Name: _____

Plan or Group # _____

Effective date: _____End Date: _____

Which health plan is the HRA linked to:_____

How will the HRA be offered on COBRA?

- ☐ Bundled – when members elect the medical plan, they automatically receive the HRA on COBRA.
- ☐ Offered Separately – Members can enroll in the medical only, or the medical and HRA. (Never the HRA alone)

Do the medical plan rates on the previous page include the HRA amount already?

- ☐ YES
- ☐ NO – the rates below need to be factored in

RATES/PREMIUM AMOUNTS

Please note: ABG COBRA cannot calculate your COBRA rate. If unsure, contact your HRA Administrator. If that is ABG, you can review additional information here: HRAs & COBRA

First year HRAs can use the following formula to determine the rate: *Total Amt of Benefit x .73 divided by 12 = monthly premium*

TIER NAME:	MONTHLY PREMIUM RATES:
☐ Member Only	_____
☐ Member + 1	_____
☐ Member + Family	_____
☐ Flat Rate	_____
☐ Other(please explain)	_____

TERMINATION RULES

Event Type	EOM	DOE	OTHER*
Termination/ 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:* _____

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 FLEXIBLE SPENDING ACCOUNT (FSA)

Carrier Name: _____

Plan or Group # _____

Plan Year Start Date: _____

Plan Year End Date: _____

RATES/PREMIUM AMOUNTS

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 information can come over on the file.

TERMINATION RULES

The ABG COBRA Portal will be set up to automatically offer the FSA for the day after the qualifying event in line with IRS rules. If your FSA terminates at the end of the month, please notify us during implementation.

ADDITIONAL PLAN

Plan Type: ☐ RX Only ☐ EAP ☐ Other _____

Carrier Name: _____

Plan Name: (HMO, PPO) _____

Plan or Group # _____

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)

RATES/PREMIUM AMOUNTS

☐ **RATE BASED ON COVERAGE LEVEL: COMPOSITE**

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

TIER NAME:	**MONTHLY PREMIUM RATES:**
Member Only	_____
Member + Spouse	_____
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 1st 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/ 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 Plan Information Form 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.