COBRA Benefit Setup Form

beneliance

Employer Group Information:

Employer Group Name _____

Employer Contact Name: _____ Employer Phone #: _____

Employer Email Address: _____

Division Name (s): _____

If different benefits per Divisions, please fill out the Cobra Benefit Set-up for each Division that differs

Broker Information:

Brokerage Name: _____

Broker or Agent Name: _____ Broker Phone #: _____

Broker or Brokerage Email Address: _____

Take Over Questions:

Are there currently any Qualified Beneficiaries? _____ Yes ____ No

Are there currently any Cobra participants? _____ Yes ____ No

Set-up Questions:

How will we receive the terminations moving forward? _____ Email from HR ____ Process in System ____ File Feed

____Other/Combination, Please Explain _____

Initial Notices go out to whom: _____ All Employees _____ New Hires Only ____Process Internally/Other Vendor (Payroll)

____ Other/Combination, Please Explain _____

Do you offer the following benefits? (Select all that apply): ____ LFSA _____ HRA _____ FSA.

Remittance:

How would you like to receive remittance of premiums? (Processed Monthly) _____Check _____ACH (Additional form required)

Notifications:

Does the client or broker activate/terminate coverage or will Beneliance be sending notices to the Carrier?

____ Beneliance (Must include all Carrier Email addresses below if option selected)

____ Client, Contact Name and Email Address _____

____ Broker, Contact Name and Email Address _____

____ Other, Contact Name and Email Address_____

Signature: _____ Date: _____

PLAN 1 INFORMATION

Plan 1 Coverage Type ☐ Medical ☐ Vision ☐ Dental ☐ Other _____

_____ _____
Carrier Name Carrier Group #:

_____ _____
Carrier Contact Name Carrier Contact Email Address

_____
Street Address

_____ _____ _____ _____ - _____
City State Zip Code Effective Date End Date

Employee Benefit Termination Schedule

_____ Month End _____Date of Termination _____Other

Dependent Benefit Termination Schedule

____ Month End ____Date of Termination ___Other

Employer Monthly Cost (not including Cobra 2% Admin Fee – but total Employer + Employee Pays)

Employee Only: $_____ Employee + Child(ren): $_____ Other (tier name): _____ Cost: $_____

Employee + Spouse: $_____ Employee + Family: $_____

PLAN 2 INFORMATION

Plan 2 Coverage Type ☐ Medical ☐ Vision ☐ Dental ☐ Other _____

_____ _____
Carrier Name Carrier Group #:

_____ _____
Carrier Contact Name Carrier Contact Email Address

_____
Street Address

_____ _____ _____ _____ - _____
City State Zip Code Effective Date End Date

Employee Benefit Termination Schedule

_____ Month End _____Date of Termination _____Other

Dependent Benefit Termination Schedule

____ Month End ____Date of Termination ___Other

Employer Monthly Cost (not including Cobra 2% Admin Fee – but total Employer + Employee Pays)

Employee Only: $_____ Employee + Child(ren): $_____ Other (tier name): _____ Cost: $_____

Employee + Spouse: $_____ Employee + Family: $_____

PLAN 3 INFORMATION

Plan 3 Coverage Type ☐ Medical ☐ Vision ☐ Dental ☐ Other _____

_____ _____
Carrier Name Carrier Group #:

_____ _____
Carrier Contact Name Carrier Contact Email Address

_____
Street Address

_____ _____ _____ _____ - _____
City State Zip Code Effective Date End Date

Employee Benefit Termination Schedule

_____ Month End _____Date of Termination _____Other

Dependent Benefit Termination Schedule

____ Month End ____Date of Termination ___Other

Employer Monthly Cost (not including Cobra 2% Admin Fee – but total Employer + Employee Pays)

Employee Only: $_____ Employee + Child(ren): $_____ Other (tier name): _____ Cost: $_____

Employee + Spouse: $_____ Employee + Family: $_____

PLAN 4 INFORMATION

Plan 4 Coverage Type ☐ Medical ☐ Vision ☐ Dental ☐ Other _____

_____ _____
Carrier Name Carrier Group #:

_____ _____
Carrier Contact Name Carrier Contact Email Address

_____
Street Address

_____ _____ _____ _____ - _____
City State Zip Code Effective Date End Date

Employee Benefit Termination Schedule

_____ Month End _____Date of Termination _____Other

Dependent Benefit Termination Schedule

____ Month End ____Date of Termination ___Other

Employer Monthly Cost (not including Cobra 2% Admin Fee – but total Employer + Employee Pays)

Employee Only: $_____ Employee + Child(ren): $_____ Other (tier name): _____ Cost: $_____

Employee + Spouse: $_____ Employee + Family: $_____

PLAN 5 INFORMATION

Plan 5 Coverage Type ☐ Medical ☐ Vision ☐ Dental ☐ Other _____

_____ _____
Carrier Name Carrier Group #:

_____ _____
Carrier Contact Name Carrier Contact Email Address

_____
Street Address

_____ _____ _____ _____ - _____
City State Zip Code Effective Date End Date

Employee Benefit Termination Schedule

_____ Month End _____Date of Termination _____Other

Dependent Benefit Termination Schedule

____ Month End ____Date of Termination ___Other

Employer Monthly Cost (not including Cobra 2% Admin Fee – but total Employer + Employee Pays)

Employee Only: $_____ Employee + Child(ren): $_____ Other (tier name): _____ Cost: $_____

Employee + Spouse: $_____ Employee + Family: $_____

PLAN 6 INFORMATION

Plan 6 Coverage Type ☐ Medical ☐ Vision ☐ Dental ☐ Other _____

_____ _____
Carrier Name Carrier Group #:

_____ _____
Carrier Contact Name Carrier Contact Email Address

_____
Street Address

_____ _____ _____ _____ - _____
City State Zip Code Effective Date End Date

Employee Benefit Termination Schedule

_____ Month End _____Date of Termination _____Other

Dependent Benefit Termination Schedule

____ Month End ____Date of Termination ___Other

Employer Monthly Cost (not including Cobra 2% Admin Fee – but total Employer + Employee Pays)

Employee Only: $_____ Employee + Child(ren): $_____ Other (tier name): _____ Cost: $_____

Employee + Spouse: $_____ Employee + Family: $_____