# Consumer Health Solutions TPA Setup for: Health Account & COBRA

**Instructions:**

1. Client information, Bank information, and Authorization page are required.
2. Complete the applicable pages for plan setup.
3. Client must sign off on the authorization page.
4. Return to applicable teams once completed: HealthAccounts@consumerhealthsolutions and/or COBRA@consumerhealthsolutions.com

Use the table of contents below to automatically jump to the pages needed for completion.

## Table of Contents




HealthAccounts@ConsumerHealthSolutions.com
COBRA@ConsumerHealthSolutions.com.com
Phone: 877-230-8650
Fax: 978-451-0981

## Client Information

| | | | |
|---|---|---|---|
| Employer's Legal Name: | | | |
| Mailing Address: | City: | State: | Zip: |
| Street Address: | City: | State: | Zip: |
| Tax ID: | Organization Type: ☐ C-Corp ☐ S-Corp* ☐ Non-Profit ☐ LLC* ☐ Church ☐ Government Entity ☐ Sole Proprietorship ☐ Other-Tax Exempt | | |

***S-Corp and LLC 2% or more owners and their family members are not eligible for the certain tax-advantaged plans due to IRS rules. Employers are responsible for ensuring owner eligibility in all plans including section 125, FSA, HSA, HRA, etc. Please provide a list of owners to Consumer Health Solutions Health Accounts.**

| | |
|---|---|
| Divisions? ☐ Yes* ☐ No | *If Yes – List Divisions: |
| Is separate reporting needed for divisions? ☐ Yes* ☐ No | *If Yes – Divisional reporting/billing notes: |
| Payroll Provider: | Benefit Administration Platform (PlanSource, GoCo, Employee Navigator, etc.): |

**Integration with payroll provider or benefit platform for enrollment changes, contributions, and COBRA:** ☐ Yes ☐ No
If yes, implementation time can range from 2 to 12 weeks and the cost is $180 annually ($15/mo.) If interested, please email HealthAccounts@crossagency.com for next steps.

| | |
|---|---|
| Total Number of Employees: | Number of Benefit Eligible Employees: |

## Contact Information

| | | |
|---|---|---|
| Primary Contact: | Title: | Employer Portal Access? ☐ Yes ☐ No |
| E-Mail: | Phone: | ☐ Health Accounts ☐ COBRA |
| Secondary Contact: | Title: | Employer Portal Access? ☐ Yes ☐ No |
| E-Mail: | Phone: | ☐ Health Accounts ☐ COBRA |
| Additional Contact: | Title: | Employer Portal Access? ☐ Yes ☐ No |
| E-Mail: | Phone: | ☐ Health Accounts ☐ COBRA |
| Additional Contact: | Title: | Employer Portal Access? ☐ Yes ☐ No |
| E-Mail: | Phone: | ☐ Health Accounts ☐ COBRA |

## Broker/Account Executive

| | | |
|---|---|---|
| Producer Name and Location: | | |
| Account Executive: | Email: | Phone: |

**Please white-list our email address "DoNotReply@consumerhealthsolutions.com" to ensure email notifications (invoices, reports, receipt requests) are received.**

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## Plan Information

| | |
|---|---|
| ☐ Health Reimbursement Arrangement<br>(HRA, QSEHRA, or ICHRA – Please specify) _____<br>☐ Transportation ☐ Parking<br>☐ Tuition Reimbursement<br>☐ Adoption Reimbursement | ☐ **COBRA**<br>☐ Health Savings Accounts (HSA)<br>☐ Limited Purpose FSA<br>☐ Flexible Spending Accounts (FSA)<br>☐ Dependent Care Spending Accounts (DCFSA)<br>☐ Lifestyle Spending Account |

Live Date:

Plan Year: (Ex. January 1 – December 31)

☐ Short plan year (If short plan is FSA- Proration of Dependent Care election is required; Health Care is recommended)

## Additional Plan Information **(Health Accounts)**

| | | |
|---|---|---|
| **Benefits Eligibility** | Hours Worked/Week (to qualify for benefits) | Waiting Period for New Employees (Ex. 30 Days, 1st Mo. After DOH) |
| | | |
| **Section 125: Plan Documents** | ☐ CHS already does our plan documents<br>☐ No, we do not need CHS to do our plan documents<br>☐ I would like CHS to do our plan documents | |
| **Payroll Frequency** | ☐ Weekly (52) ☐ Bi-Weekly (26) ☐ Semi Monthly (24) ☐ Monthly (12)<br>☐ Other _____ | **1st Deduction Date within benefit plan year:** MM/DD/YY |

## COBRA Administration (Informational Use)
## If not administered by Consumer Health Solutions

HRAs are considered Health Plans and are subject to COBRA

Who handles your COBRA Administration? ☐ TPA ☐ In-house ☐ Other**

**Please provide your COBRA provider's information: Telephone:

Address: City: State: Zip:

Is enrollment in the HRA linked to participation in a medical insurance plan?

☐ Yes- Please name the plan(s):

Are Cobra participants allowed to elect the medical insurance plan WITHOUT the HRA?

☐ Yes- COBRA participants may elect medical coverage with or without the HRA

☐ No- Participation in this medical plan automatically includes participation in the HRA

☐ No- HRA coverage is separate from medical insurance coverage

## Employer Bank Account Setup

| Use For: Select Those Applicable | Account Type: ** ☐ Checking ☐ Savings |
|---|---|
| ☐ Reimbursements<br>☐ Debit Card Funding<br>☐ Billing<br>☐ HSA Funding<br>☐ COBRA *(See below for mail check reimbursement)* | Routing Number: **:<br><br>Account Number: ** : |

Bank Name: **:

Bank Address:

Street: City: State: Zip

Please note if a second bank account should be used for specific purposes (example: COBRA)

Does this bank account utilize positive pay to prevent deposits/withdrawals? ☐ Yes* ☐ No

*If yes: CHS can provide our bank information to be added as an authorized account to deposit & withdraw funds. Providing this information prior to the plan start will prevent any delays in reimbursement to employees.

## COBRA Premium Reimbursement by Mail

For premium reimbursement through check, please complete the following information.

Pay to the order of:

Attention to:

Mailing Address:

## Fees (As Established in Proposal)

| **Health Account Administration Fees:** | **Debit Card Fees:** | **Other Fees:** |
|---|---|---|
| Setup/Renewal Fee: **As established in proposal.**<br>Per Active Participant Per Month: **As established in proposal.** | Initial Set of Debit Cards: $0<br>Additional Set of replacement Cards: $5 (Charged to the Participant unless otherwise indicated by employer) | • Discrimination Testing Fee: $150<br>• Mid-year termination fee (prior to 30 days before the end of the plan year): $300<br>• Mid-year plan change fee: Minimum $200<br>• Outside administrator plan takeover: $300 |

**COBRA Fees:**

| **Ongoing Administration:** | **COBRA Monthly Administration Fee:** Based on number of benefit eligible employees at time of setup and recalculated annually at renewal. |
|---|---|
| 2% of premium billed per COBRA elected participant.<br>(Collected from the participant) | **As established in proposal.** |

# Plan Authorization

***Instructions***: Please complete this plan authorization page after all plan information has been entered in the below pages. This authorization certifies that all plan information provided is correct. This form is required to be signed before Consumer Health Solutions will initialize/go live with the plans.

Please contact Health Accounts or COBRA at Consumer Health Solutions with any plan questions prior to signing the authorization.

*I hereby certify that the information provided in the Health Accounts and COBRA plan setup is accurate.*

*I understand that:*

- *Consumer Health Solutions will build and initialize the plans based on the information provided in these documents.*
- *Changes to the plans after the setup will result in a minimum fee of $200.*
- *Consumer Health Solutions will initialize the plans once the authorization page is provided.*

Company Name:

Authorizer Name:

| Signature: | Date: |
| --- | --- |

Consumer Health Solutions



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# Consumer Health Solutions

# Health Accounts Intake Forms

***This form is required if the plan utilizes debit card***

Payment Solutions
The Bancorp Bank
America's Leading Private-Label Banking Resource

MEMBER FDIC
Banking Services Provided by The Bancorp Bank



## AUTHORIZATION FOR ACH DEBITS / CREDITS

_____

**Depositor Name as Shown on Bank Records**

_____

**Checking Account Number/ Transit Routing Number**
*(A voided check or spec sheet **must** be attached for this account)*

**TO:** _____

_____

(Bank Address: Street, Box #, City, State and Zip Code)

Depositor authorizes The Bancorp Bank to present automated debits and credits to and from the above listed account as required to perform their responsibilities related to processing Depositor's benefit program. This authorization will remain in effect until revoked by Depositor in writing and until you actually receive such notice Depositor agrees that you shall be fully protected in honoring any such ACH transaction.

Depositor agrees that your treatment of each such ACH transaction and your rights in respect to it shall be the same as if it were a check signed by Depositor.

I authorize payments to be withdrawn daily or weekly as needed.

**Dated this_____day of_____, 20_____.**

_____

**Signature of Depositor in Agreement with Bank Records**

Please update your ACH filter (on the above reference account) to grant access to The Bancorp Bank. The Bancorp Bank identification number is: **1050006509**.



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## Flexible Spending Account (FSA)

| Company Name: | Plan Name (Displayed to Employees) : |
|---|---|

Who handles your COBRA administration? Handled in house? ☐ Yes ☐ No By TPA? ☐ Yes ☐ No

If administered by another provider please add providers name, phone number and address below:

COBRA Provider's Name: Telephone:

Address: City: State: Zip:

Is your plan subject to FMLA? ☐ Yes* ☐ No *(*In most cases companies with 50 employees or more are subject to FMLA)*

| | Maximum Election | Minimum Election | Employer Contribution |
|---|---|---|---|
| Health Care Flexible Spending Account (FSA) | $3,200 (2024)<br>$ | $ | $ |
| Dependent Care Flexible Spending Account (DCFSA) | $5,000 (2024)<br>$ | $ | $ |

2 ½ Month Grace Period: ☐ Yes ☐ No

Rollover: ☐ Yes 2024 $640.00 or 2025 IRS Limit ☐ Yes, other amount ☐ No Rollover

When will rollover take place: ☐ 1st day of the new plan year ☐ after runout

Run out after plan year end: ☐ 90 Days (TPA'S Default) ☐ Other:

Will TPA be handling the run-out for the previous FSA provider? ☐ Yes ☐ No

## Dependent Care Spend Down

If an employee terminates participation in the Dependent Care Reimbursement Accounts, can they continue to be reimbursed for Eligible dependent care expenses through the end of the plan year? ☐ Yes* ☐ No *TPA' default

Note: Reimbursement will not exceed amount contributed by employee prior to plan termination

## Notes

Other notes and rules for CHS team to be aware of:

# Health Reimbursement Arrangement (HRA)

Company Name:

Plan Name (Displayed to Employees), example: HRA :

## Plan Specifics

List the name of all medical insurance plan(s) subject to the HRA:

**Please attach a copy of your medical insurance benefit summary*

For **deductible** HRAs- does the deductible run: ☐ Calendar year ☐ Insurance year/Plan year?

Does your current deductible have a carryover feature? If so please explain:

If an HRA is already in place, will TPA be handling the run-out for the previous HRA provider? ☐ Yes* ☐ No

**If Yes, please provide the pertinent demographic and balance information*

### HRA Claim Submission

☐ Manual Claim Submission (Deductible Based Claims)
☐ Direct File Feed ( ☐ TPA Stream ☐ Other_____ )
☐ Debit Card (nondeductible HRA plan…Review first with CHS Team)

## Employer HRA Contribution

| The HRA Pays: ☐ First Portion ☐ Second Portion | | The Employee Pays: ☐ First Portion ☐ Second Portion | |
|---|---|---|---|
| $ | Flat Dollar Amount | $ | Flat Dollar Amount |
| $ | Single Person Plan | $ | Single Person Plan |
| $ | Two Person Plan | $ | Two Person Plan |
| $ | Family Plan | $ | Family Plan |

$ *Per Member Maximum for HRA

*Per Member HRA Maximum on the Family Plan (choose one below)

☐ There is no per member maximum on the deductible- Any family member or combination of family members must meet the full employee responsibility before the HRA will pay any claims. (DF) **Aggregate**

☐ There is a per member maximum- One family member must meet their full employee responsibility before the HRA will pay any claims for that member. Should one family member never meet the full responsibility on their own then any combination of family members can meet the employee responsibility to have HRA claims pay out. (DW) **Embedded**

☐ There is a per member maximum- Two family members must meet their full employee responsibility before the HRA will pay any claims for that member. Once two family members have met their portion of the deductible any combination of family members can meet the remaining deducible to have HRA claims paid out. (DE)

☐ A strict per member maximum- each family member must meet their full employee responsibility, then HRA will begin to pay once the family deductible is met. (DM)

## HRA Allowable Expenses

☐ Only Health Plan Deductible

☐ Check here if prescriptions are applied to the deductible

☐ Other:

*S-Corp and LLC 2% or more owners and their family members are not eligible for the HRA plan
Please Provide a list of any 2% or more owners:

Are Domestic Partner claims eligible for reimbursement by HRA? ☐ No* ☐ Yes
*Domestic Partners are typically not eligible

When are HRA funds available to participants?

☐ Whole Amount Up Front *(Beginning of Plan Year)* ☐ Other (1st of Quarter, 1st of Mo., Payroll Frequency, Custom)

| | |
|---|---|
| Are Funds Pro-Rated Monthly? ☐ Yes ☐ No* | Funds Carryover: ☐ Yes, full balance carry over ☐ No ☐ Other: |

Run out after plan year end: ☐ 90 Days (TPA'S Default) ☐ Other:

NOTES:

Other notes and rules for CHS team to be aware of:

## Commuter Benefit Plans

Company Name:

| **Parking Plan Name** (Displayed to Employees): | **Transportation Plan Name** (Displayed to Employees): |
|---|---|
| | |

### Plan Design

☐ **Parking Reimbursement Account**- Purchases can be made using the Debit Card or by submitting a claim for reimbursement

| | | | | |
|---|---|---|---|---|
| Pre-tax Monthly Minimum Election | $ | Post- tax Monthly Minimum Election | $ | Employer Contribution: $ |
| Pre-tax Monthly Maximum Election IRS Max 2024: $315 | $ | Post- tax Monthly Maximum Election | $ | |

Will you be offering the Debit Card? ☐ Yes ☐ No

☐ **Transportation Reimbursement Account**- Purchases can be made using the Debit Card or by submitting a claim for reimbursement

| | | | | |
|---|---|---|---|---|
| Pre-tax Monthly Minimum Election | $ | Post- tax Monthly Minimum Election | $ | Employer Contribution: $ |
| Pre-tax Monthly Maximum Election IRS Max 2024: $315 | $ | Post- tax Monthly Maximum Election | $ | |

**Run out after plan year end:** ☐ 90 Days (TPA'S Default) ☐ Other:

### Notes

Other notes and rules for CHS team to be aware of:

# Health Savings Account

**Employer Name:**

**Plan Display Name (Visible to Employees):**

## Plan Information

**HSA Contribution File Notification:**

☐ Payroll File Feed (cost associated) ☐ Self Service in Employer Portal ☐ Direct ACH transfer from payroll to HSA

☐

**Will you be offering a Limited Purpose FSA?** ☐ Yes ☐ No

**Will the HSA have an employer contribution associated with it?** ☐ Yes* ☐ No

*If yes, please complete section below.

## Employer Contribution (If Applicable)

**What will the employer contribution be?** Individual: $ Family: $

**When will the Employer Contribution be made given?**

☐ Whole amount up front ☐ Pro-rated Per Payroll

☐ Pro-rated Monthly ☐ Pro-rated Quarterly

☐ Other

**Additional contribution information:**

**Fee:**

Please indicate any fees the Employer will pay (**HSA Service Fee**), fees will be passed to participant otherwise.

| Fee Name: | Description: | Schedule: | Applied To: | Amount: |
|---|---|---|---|---|
| HSA Returned Item Fee | Apply a fee for each distribution transaction that needs to be returned due to insufficient funds. | Upon Trigger Event | Consumer | $25.00 |
| HSA Service Fee | Apply an HSA scheduled service fee. | The 1st of Every Month | **Employer** | $2.50 |
| HSA Check Distribution Fee | Apply a fee each time an HSA check distribution is requested. | Upon Trigger Event | Consumer | $2.50 |
| HSA Printed Account Summary Fee | Apply a fee each time an HSA Account Summary is printed. | Upon Trigger Event | Consumer | $5.00 |
| HSA Closure Fee | Apply a fee for the processing of an HSA closure. | Upon Trigger Event | Consumer | $15.00 |

# Health Reimbursement Arrangement (QSEHRA or ICHRA)

Company Name: Plan Dates:

Plan Name (Displayed to Employees) : Ex: "ICHRA", "QSEHRA" or "Individual Coverage HRA" :

## Plan Specifics

### ICHRA/QSEHRA Claim Submission

□ Manual Claim Submission (Online portal/app w substantiation required)
□ HSA Insurance List Bill (Groups over 10 with prior discussion)
□ Debit Card (nondeductible HRA plan)

## Employer HRA Contribution

### The HRA Pays:

| | |
|---|---|
| ☐ | Age rates (Please provide age rates in the census in "Employer Contribution" and specify fund availability below) |
| $ | Flat Dollar Amount |
| $ | Single Person Plan |
| $ | Two Person Plan |
| $ | Family Plan |

### Check all eligible expenses:

☐ Premiums ( ☐ Medical Only ☐ Medical Dental & Vision

☐ 213(d) Eligible Expenses (Medical Expenses, Drugs & Medicine, Hearing Impairment, Mental Health Services)

Substantiation Process (Required if debit card is selected) – Default substantiation process is to use the debit card and upload the receipts with required details via the online portal or email/fax to CHS Health Accounts. Emails will be sent to employees asking for required documentation. Failure to upload the documentation after multiple requests will result in the debit card suspension until documentation or repayment is received. Please note: debit card suspension does not mean the benefit it suspended – employees can submit claims via the online portal or app for reimbursement.

1. What claims should be auto substantiated? □ Premiums Only □ 213(d) expenses only □ Both
2. Do you want to allow auto substantiation for certain expenses up to a certain dollar amount?
    a. Typically, clients auto substantiate 213(d) expenses up to $150.
    b. Claims for above the specified dollar amounts below will require the employee to upload documentation to substantiate the claim.

□ Premiums – Amounts below $_____ or □ all expenses
□ Medical – Amounts below $_____ or □ all expenses
□ Dental – Amounts below $_____ or □ all expenses
□ Vision – Amounts below $_____ or □ all expenses
□ Pharmacy – Amounts below $_____ or □ all expenses
If auto substantiation is selected, CHS will prepare a hold harmless agreement for client signature.

### When are ICHRA/QSEHRA funds available to participants?

□ Monthly*Most common □ Whole Amount Up Front *(Beginning of Plan Year)* □ Quarterly □ Payroll Frequency

## Eligibility

Which permissible "classes" of employees will be offered the ICHRA?

□ Full Time □ Part Time □ Seasonal □ Salaried □ Hourly □ Other_____

New Hire Eligibility: Must be first of the month

Rollover at the end of plan year:

Will funds roll over to next plan year? □ No*Most Common □ Yes: $_____

Run out after plan year end: □ 90 Days (TPA'S Default) □ Other:

## Notes

Other notes and rules for CHS team to be aware of:

# Tuition Reimbursement Arrangement

Company Name:

Plan Name (Displayed to Employees), example: "Tuition Reimbursement Plan":

## Plan Specifics

If a Tuition Reimbursement plan is already in place, will TPA be handling the run-out for the previous Tuition Reimbursement provider? ☐ Yes* ☐ No **If Yes, please provide the pertinent demographic and balance information*

### Tuition Claim Submission

☐ Manual Claim Submission

## Employer Contribution

The Tuition Plan Pays:

$ Flat Dollar Amount per year (limit $5,250)

## Allowable Expenses

- ☐ Admin Fees
- ☐ Application Fees
- ☐ Book Fees
- ☐ Campus Fee
- ☐ General University Fee
- ☐ Graduation Fees
- ☐ Lab Fees
- ☐ Part Time Student Fees
- ☐ Pharm Tech Fees
- ☐ Registration Fees
- ☐ Required Exam Fees (LSAT, GMAT, Etc.)
- ☐ School Fee
- ☐ Supply Fees (Directly related to course work)
- ☐ Technology Fees
- ☐ Transfer Credit Fees
- ☐ Miscellaneous Fees

When are Tuition funds available to participants?

☐ Whole Amount Up Front *(Beginning of Plan Year)* ☐ Per Course enrolled

☐ Other (1st of Quarter, 1st of Mo., Payroll Frequency, Custom)

If other: Are Funds Pro-Rated Monthly ? ☐ Yes ☐ No*

Is a passing grade required to be reimbursed?

If employees can submit for reimbursement prior to course completion, and a passing grade is not received, repayment by the employee would be requested.

☐ Yes ☐ No

If yes: what required grade and percentage:

How long after the course ends do employees have to submit their receipt?

☐ 60 ☐ 90 ☐ 180 (Number of Days)

If questions arise, who is the employer contact related to the plan?

Run out after plan year end: ☐ 90 Days (TPA'S Default) ☐ Other:

**Please Note:** A terminated employee's plan year end date is their termination date with a 90-day run out period to file claims they incurred when eligible.

## Notes

Other notes and rules for CHS team to be aware of:

# Adoption Assistance Program

Company Name:

Plan Name (Displayed to Employees), example: "Adoption Assistance Program":

## Plan Specifics

If an Adoption Assistance Program is already in place, will TPA be handling the run-out for the previous provider?

☐ Yes* ☐ No **If Yes, please provide the pertinent demographic and balance information*

## Adoption Claim Submission

☐ Manual Claim Submission

## Employer Contribution

The Adoption Plan Pays:

$ Flat Dollar Amount (IRS Maximum $16,810 for 2024)

## Allowable Expenses

☐ Adoption Fees ☐ Attorney Fees ☐ Court Fees ☐ Traveling Expenses

☐ Other Adoption Related Expenses

When are Adoption funds available to participants?

☐ Whole Amount Up Front *(Beginning of Plan Year)*

Run out after plan year end: ☐ 90 Days (TPA'S Default) ☐ Other:

**Please Note:** A terminated employee's plan year end date is their termination date with a 90-day run out period to file claims they incurred when eligible.

## Notes

Other notes and rules for CHS team to be aware of:

# Lifestyle Spending Account Program

Company Name:

Plan Name (Displayed to Employees), example: "Lifestyle Reimbursement Program":

## Plan Specifics

If a Lifestyle Spending Account Program is already in place, will TPA be handling the run-out for the previous provider?

☐ Yes* ☐ No **If Yes, please provide the pertinent demographic and balance information*

### Lifestyle Spending Account Claim Submission Method

☐ Manual Claim Submission
☐ Debit Cards (if available – Speak with Health Accounts prior to this selection)

## Employer LSA Contribution

The LSA Plan Pays:

| $ | ☐ Per Month ☐ Per Year<br>☐ Per Individual ☐ Per Family |
|---|---|

## Allowable Expenses

### Physical Wellness

- ☐ Athletic Equipment & Accessories
- ☐ Gym, Membership
- ☐ Fitness Studio Membership
- ☐ Fitness Classes (yoga, Pilates, spin/cycle, dance, etc.)
- ☐ Lessons (golf, swimming, tennis, dance etc.)
- ☐ Personal Trainer
- ☐ Fitness Trackers (Fitbit)
- ☐ Entry Fee (marathon, leagues, etc.)
- ☐ Passes (ski, snowboard, golf, swimming)

### Financial Wellness

- ☐ Student Loan Reimbursement
- ☐ Home Purchase Expense Reimbursement (down payment closing costs, etc.)
- ☐ Financial advisor & planning services
- ☐ Financial Seminars and Classes
- ☐ ID Theft Protection Services
- ☐ Pet Insurance Premiums

### Emotional Wellness

- ☐ Meditation Classes
- ☐ Retreats (leadership, spiritual, etc.)
- ☐ Pet Care (walkers, day care, grooming, etc.)
- ☐ Camping (equipment, fees, etc.)
- ☐ Personal Development Classes (art, cooking, etc.)
- ☐ Annual Park Passes
- ☐ Hunting and Fishing Licenses

☐ Other expenses:

Run out after plan year end: ☐ 90 Days (TPA'S Default) ☐ Other:

**Please Note:** A terminated employee's plan year end date is their termination date with a 90-day run out period to file claims they incurred when eligible.

Who is eligible for the LSA? ☐ All Benefits Eligible ☐ Medical Enrollees Only

Who is covered by the LSA? ☐ Employee ONLY ☐ Employee and their family

## Notes

Other notes and rules for CHS team to be aware of:

## COBRA Information

| **Company Name:** | | | |
|---|---|---|---|
| **Which plans are eligible for COBRA:** | ☐ Medical # of Plans:<br>☐ Dental # of Plans:<br>☐ Vision # of Plans:<br>☐ Rx Standalone # of Plans:<br>☐ FSA<br>☐ HRA<br>☐ EAP<br>☐ Other: | **Current COBRA Administration:** | ☐ Self<br>☐ **Third Party: Name of current administrator** |
| **# of Enrolled QBs:** | | **# of Pending QBs:** | |
| **Are there any pending COBRA appeals?** | ☐ Yes, please explain<br>☐ No | | |
| **Do you offer subsidies or severance packages?** | ☐ Yes, please explain<br>☐ No | **Are you subject to State Continuation?** | ☐ Yes, please list the state(s) below<br>☐ No |

## Medical Plan Information:

### Medical Plan 1

| | | | |
|---|---|---|---|
| **Carrier Name:** | | **Plan Name:** | |
| **Plan Type:** | | **Available for what divisions:** | ☐ All<br>☐ Specify which divisions: |
| **Plan Policy ID:** | | **Insured:** | ☐ Fully Insured<br>☐ Self-Insured |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **Conversion to Individual plan allowed?** | | **Rate Effective Date** | |
| **For age banded rates, when do premiums change?** | ☐ Enrollment date<br>☐ Birthday<br>☐ Plan Renewal Date | | |

| **Enter Monthly COBRA Premiums: (do not include the 2% admin fee)** | **Premium Level** | **Composite Premium Amount** |
|---|---|---|
| | **Employee Only** | $_____ |
| | **Employee + Spouse** | $_____ |
| | **Employee + Children** | $_____ |
| | **Employee + Family** | $_____ |

**If rates are age-banded or otherwise non-composite, please attach the rate information separately.**

## Dental Plan Information:

### Dental Plan 1

| | | | |
|---|---|---|---|
| **Carrier Name:** | | **Plan Name:** | |
| **Plan Type:** | | **Available for what divisions:** | ☐ All<br>☐ Specify which divisions: |
| **Plan Policy ID:** | | **Insured:** | ☐ Fully Insured<br>☐ Self-Insured |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **Conversion to Individual plan allowed?** | | **Rate Effective Date** | |
| **For age banded rates, when do premiums change?** | ☐ Enrollment date<br>☐ Birthday<br>☐ Plan Renewal Date | | |

| Enter Monthly COBRA Premiums: (do not include the 2% admin fee) | Premium Level | Composite Premium Amount |
|---|---|---|
| | **Employee Only** | $_____ |
| | **Employee + Spouse** | $_____ |
| | **Employee + Children** | $_____ |
| | **Employee + Family** | $_____ |

**If rates are age-banded or otherwise non-composite, please attach the rate information separately.**

## Vision Plan Information:

| | | | |
|---|---|---|---|
| **Carrier Name:** | | **Plan Name:** | |
| **Plan Type:** | | **Available for what divisions:** | ☐ All<br>☐ Specify which divisions: |
| **Plan Policy ID:** | | **Insured:** | ☐ Fully Insured<br>☐ Self-Insured |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **Conversion to Individual plan allowed?** | | **Rate Effective Date** | |
| **For age banded rates, when do premiums change?** | ☐ Enrollment date<br>☐ Birthday<br>☐ Plan Renewal Date | | |
| | | | |
| | | | |
| | | | |

| Enter Monthly COBRA Premiums: (do not include the 2% admin fee) | Premium Level | Composite Premium Amount |
|---|---|---|
| | **Employee Only** | $_____ |
| | **Employee + Spouse** | $_____ |
| | **Employee + Children** | $_____ |
| | **Employee + Family** | $_____ |

**If rates are age-banded or otherwise non-composite, please attach the rate information separately.**

## HRA (if applicable)

| | | | |
|---|---|---|---|
| **Administrator Name:** | | **Applies to:** | ☐ All available medical plans<br>☐ Specific medical plans (list plan IDs below) |
| **Plan Policy ID:** | | | |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | | |
| **Maximum Annual Reimbursement Amount** | **Employee Only:**<br>**Employee + Spouse:**<br>**Employee + Children:**<br>**Employee + Family:** | **Prior Year's Utilization Percentage** | |

## FSA (if applicable)

| | | | |
|---|---|---|---|
| **Administrator Name:** | | **Plan Name:** | |
| **Plan Policy ID:** | | | |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **FSA Renewal Month:** | | | |

## Other Plan Offerings

| | | | |
|---|---|---|---|
| **Carrier Name:** | | **Plan Name:** | |
| **Plan Type:** | | **Available for what divisions:** | ☐ All<br>☐ Specify which divisions: |
| **Plan Policy ID:** | | **Insured:** | ☐ Fully Insured<br>☐ Self-Insured |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **Conversion to Individual plan allowed?** | | **Rate Effective Date** | |
| **For age banded rates, when do premiums change?** | ☐ Enrollment date<br>☐ Birthday<br>☐ Plan Renewal Date | | |

| **Enter Monthly COBRA Premiums: (do not include the 2% admin fee)** | **Premium Level** | **Premium Amount** |
|---|---|---|
| | **Employee Only** | $_____ |
| | **Employee + Spouse** | $_____ |
| | **Employee + Children** | $_____ |
| | **Employee + Family** | $_____ |

## Other Plan Offerings

| | | | |
|---|---|---|---|
| **Carrier Name:** | | **Plan Name:** | |
| **Plan Type:** | | **Available for what divisions:** | ☐ All<br>☐ Specify which divisions: |
| **Plan Policy ID:** | | **Insured:** | ☐ Fully Insured<br>☐ Self-Insured |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **Conversion to Individual plan allowed?** | | **Rate Effective Date** | |
| **For age banded rates, when do premiums change?** | ☐ Enrollment date<br>☐ Birthday<br>☐ Plan Renewal Date | | |

| **Enter Monthly COBRA Premiums: (do not include the 2% admin fee)** | **Premium Level** | **Premium Amount** |
|---|---|---|
| | **Employee Only** | $_____ |
| | **Employee + Spouse** | $_____ |
| | **Employee + Children** | $_____ |
| | **Employee + Family** | $_____ |

## Other Plan Offerings

| | | | |
|---|---|---|---|
| **Carrier Name:** | | **Plan Name:** | |
| **Plan Type:** | | **Available for what divisions:** | ☐ All<br>☐ Specify which divisions: |
| **Plan Policy ID:** | | **Insured:** | ☐ Fully Insured<br>☐ Self-Insured |
| **Carrier Contact Information:** | **Name:**<br>**Email Address:**<br>**Phone Number:**<br>**Fax Number:** | | |
| **Coverage End Date:** | ☐ Event Date<br>☐ End of Month | **Is this plan bundled with another plan?** | ☐ Yes, Indicate what plan:<br>☐ No |
| **Plan Year Dates:** | **From:**<br>**To:** | **Billing Start Date:** | |
| **Conversion to Individual plan allowed?** | | **Rate Effective Date** | |
| **For age banded rates, when do premiums change?** | ☐ Enrollment date<br>☐ Birthday<br>☐ Plan Renewal Date | | |

| **Enter Monthly COBRA Premiums: (do not include the 2% admin fee)** | **Premium Level** | **Premium Amount** |
|---|---|---|
| | **Employee Only** | $_____ |
| | **Employee + Spouse** | $_____ |
| | **Employee + Children** | $_____ |
| | **Employee + Family** | $_____ |