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 ☐ Sole Proprietorship ☐ Government Entity ☐ Other-Tax Exempt		State Incorporated:

***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:

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. If interested, please email HealthAccounts@consumerhealthsolutions.com for next steps.

Total Number of Employees:	Number of Benefit Eligible Employees:

Contact Information

Primary Contact:	Title	Email
Phone #:	□ Health Accounts □ COBRA	Portal Access □ Yes □ No
Secondary Contact:	Title	Email
Phone #:	□ Health Accounts □ COBRA	Portal Access □ Yes □ No
Additional Contact:	Title	Email
Phone #:	□ Health Accounts □ COBRA	Portal Access □ Yes □ No
Additional Contact:	Title	Email
Phone #:	□ Health Accounts □ COBRA	Portal Access □ Yes □ No
Additional Contact:	Title	Email
Phone #:	□ Health Accounts □ COBRA	Portal Access □ Yes □ No

Billing Contact*: Who should receive invoices?

Enrollment Contact*: Who should we contact re. enrollment discrepancies?

Reporting Contact*: Who should receive funding reports?

Signatory Contact*: Who should agreements be sent to?

Broker/Account Executive

Brokerage Name and Location:		
Broker Name:	Email:	Phone:
Account Manager:	Email:	Phone:

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

Plan Information

☐ Health Reimbursement Arrangement	☐ COBRA
(HRA, QSEHRA, or ICHRA – Please specify) _____	☐ Health Savings Accounts (HSA)
☐ Transportation ☐ Parking	☐ Limited Purpose FSA (Required if offering FSA and HSA)
☐ Tuition Reimbursement	☐ Flexible Spending Accounts (FSA)
☐ Adoption Reimbursement	☐ Dependent Care Spending Account
	☐ 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 Hires (Ex. 30 Days, 1st Mo. After DOH)	
	When do terminated employee's benefits end: ☐ End of the Month ☐ Date of Termination		
Leave of Absence:	**LOA: Hold Payroll Deductions?** ☐ Yes ☐ No	**LOA: Hold Employer Contributions?** ☐ Yes ☐ No	**LOA: Are new expenses eligible?** ☐ Yes ☐ No
Section 125: Plan Documents	List your pre-tax benefits offered (medical, dental, vision, HSA, etc.):		
Plan Number:	If you have an existing ERISA plan in place, what is the plan number to be used and the original plan date? Example: 501, 502, 503, 504…		
Payroll Frequency	☐ Weekly (52) ☐Bi-Weekly (26) ☐ Semi Monthly (24) ☐ Monthly (12) ☐ Other _____ ***Specify if different classes have different frequencies***		**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 ☐ Debit Card Funding ☐ Billing ☐ HSA Funding ☐ COBRA *(See below for mail check reimbursement)*	Routing Number: **: Account Number: ** :

Bank Name: **:

Bank Address:

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.** Per Active Participant Per Month: **As established in proposal.**	Initial Set of Debit Cards: $0 Additional Set of replacement Cards: $5 (Charged to the Participant unless otherwise indicated by employer)	• Discrimination Testing Fee: $150 • Mid-year termination fee (prior to 30 days before the end of the plan year): $300 Plus one month's administration fee • Mid-year plan change fee: Minimum $200 • 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. (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

Health Accounts Intake Forms

This form is required if the plan utilizes debit card

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**.

Flexible Spending Account (FSA)

Company Name:

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

What is the **original** plan effective date?	Maximum Election	Minimum Election	Employer Contribution
☐ Health Care Flexible Spending Account (FSA)	☐ Current IRS Limit OR $	$	$
☐ Dependent Care Flexible Spending Account (DCFSA)	☐ Current IRS Limit OR $	$	$

Medical FSA: Choose either a rollover option, a grace period option or neither. You cannot choose both Rollover and Grace period.

☐ Rollover Current IRS Limit OR ☐ Grace Period 2 ½ Month OR ☐ No Rollover and No Grace period

☐ Rollover other amount: ☐ Grace Period other Length:

$_____ _____

Dependent Care FSA (**Choose One**): ☐ Grace Period 2 ½ Month ☐ No Grace Period ☐ Grace Period other Length: _____

Do you want a debit card for Dependent Care? ☐ No (TPA'S Default) ☐ Yes

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

If CHS will be handling the runout, please provide plan documents for prior plan year with balances.

Do you want to include the Qualified Reservist Distribution in your plan? ☐ Yes ☐ No

The HEART Act of 2008 provides a special rule allowing distributions of unused amounts in the Flexible Spending Account to reservists ordered or called to active duty. In the event that an employee is called into active duty, you would be required to determine how distributions will be calculated.

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:

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Health Reimbursement Arrangement (HRA)

Company Name: **Medical Carrier Name:**

What is the **original** effective date?

Plan Specifics

List the name of all medical insurance plan(s) and group numbers* subject to the HRA: **Attach a copy of your medical 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
☐ Direct File Feed – Carrier: _____
☐ Carrier Pay Member ☐ Carrier Pay Provider

☐ TPA Stream – Carrier: _____
☐ Debit Card (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**

☐ Other – Provide in Notes

HRA Allowable Expenses

☐ Only Health Plan Deductible

☐ Prescription Deductible

☐ Other, be specific:

*S-Corp and LLC 2% or more owners and their immediate 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 not considered eligible dependents under IRS Section 105

When are HRA funds available to participants?

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

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):	What is the **original** effective date?

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: ☐ $_____ OR
Pre-tax Monthly Maximum Election	□ IRS Max OR □ $	Post- tax Monthly Maximum Election	$	☐ Match

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: ☐ $_____ OR
Pre-tax Monthly Maximum Election	□ IRS Max OR □ $	Post- tax Monthly Maximum Election	$	☐ Match

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

Notes

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

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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 *LPFSA is required if you offer FSA*	**What is the original section 125 Plan effective date?**

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 Monthly ☐ Other	☐ Pro-rated Per Payroll ☐ Pro-rated Quarterly
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	$2.50
HSA Closure Fee	Apply a fee for the processing of an HSA closure.	Upon Trigger Event	Consumer	$15.00

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	☐ General University Fee	☐ Pharm Tech Fees	☐ Supply Fees (Directly related to course work)
☐ Application Fees	☐ Graduation Fees	☐ Registration Fees	☐ Technology Fees
☐ Book Fees	☐ Lab Fees	☐ Required Exam Fees (LSAT, GMAT, Etc.)	☐ Transfer Credit Fees
☐ Campus Fee	☐ Part Time Student Fees	☐ School Fee	☐ 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 $17,280 for 2025)

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 ☐ 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: ☐ Dental # of Plans: ☐ Vision # of Plans: ☐ Rx Standalone ☐ FSA ☐ HRA ☐ EAP ☐ Other:	**Current COBRA Administration:**	☐ Self ☐ **Third Party: Name of current administrator**
# of Enrolled COBRA Participants:		**# of Pending COBRA participants:**	
Are there any pending COBRA appeals?	☐ Yes, please explain ☐ No		
Do you offer subsidies or severance packages?	☐ Yes, please explain ☐ No	**Are you subject to State Continuation?**	☐ Yes, please list the state(s) below ☐ No

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Medical Plan Information:

Medical Plan 1

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

Enter Monthly COBRA Premiums: (do not include the 2% admin fee) **For three tier rates, leave EE & Children blank**	**Premium Level**	**Composite Premium Amount**
	Employee Only	$_____
	Employee Spouse or Employee + 1	$_____
	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 ☐ Specify which divisions:
Plan Policy ID:		**Insured:**	☐ Fully Insured ☐ Self-Insured
Carrier Contact Information:	**Name:** **Email Address:** **Phone Number:** **Fax Number:**		
Coverage End Date:	☐ Event Date ☐ End of Month	**Is this plan bundled with another plan?**	☐ Yes, Indicate what plan: ☐ No
Plan Year Dates:	**From:** **To:**	**Billing Start Date:**	
Conversion to Individual plan allowed?		**Rate Effective Date**	
For age banded rates, when do premiums change?	☐ Enrollment date ☐ Birthday ☐ Plan Renewal Date		

Enter Monthly COBRA Premiums: (do not include the 2% admin fee) **For three tier rates, leave EE & Children blank**	**Premium Level**	**Composite Premium Amount**
	Employee Only	$_____
	Employee Spouse or Employee + 1	$_____
	Employee + Children	$_____
	Employee + Family	$_____

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

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Vision Plan Information:

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

Enter Monthly COBRA Premiums: (do not include the 2% admin fee) **For three tier rates, leave EE & Children blank**	**Premium Level**	**Composite Premium Amount**
	Employee Only	$_____
	Employee Spouse or Employee + 1	$_____
	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 ☐ Specific medical plans (list plan IDs below)
Plan Policy ID:			
Carrier Contact Information:	**Name:** **Email Address:** **Phone Number:** **Fax Number:**		
Coverage End Date:	☐ Event Date ☐ End of Month	**Is this plan bundled with another plan?**	☐ Yes, Indicate what plan: ☐ No
Plan Year Dates:	**From:** **To:**	**HRA Rates:**	***HRA rates must be provided by the employer, but CHS can assist in the calculation.***
Maximum Annual Reimbursement Amount	**Employee Only:** **Employee + Spouse:** **Employee + Children:** **Employee + Family:**	**Employee Only:**	
		Employee + 1 or Spouse:	
		Employee + Children:	
		Employee + Family:	

FSA (if applicable)

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

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Other Plan Offerings

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

Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	**Premium Level**	**Premium Amount**
For three tier rates, leave EE & Children blank	**Employee Only**	$_____
	Employee Spouse or Employee + 1	$_____
	Employee + Children	$_____
	Employee + Family	$_____

Other Plan Offerings

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

Enter Monthly COBRA Premiums: (do not include the 2% admin fee) **For three tier rates, leave EE & Children blank**	**Premium Level**	**Premium Amount**
	Employee Only	$_____
	Employee Spouse or Employee + 1	$_____
	Employee + Children	$_____
	Employee + Family	$_____

Other Plan Offerings

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

Enter Monthly COBRA Premiums: (do not include the 2% admin fee) **For three tier rates, leave EE & Children blank**	**Premium Level**	**Premium Amount**
	Employee Only	$_____
	Employee Spouse or Employee + 1	$_____
	Employee + Children	$_____
	Employee + Family	$_____