

CLIENT INFORMATION

Company Legal Name:	
DBA Name	
<i>Other Names, If applicable</i>	
Mailing Address	
Company Main Phone #	
Tax ID	
Organization Type	<input type="checkbox"/> C-Corp <input type="checkbox"/> LLC * <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> S-Corp* <input type="checkbox"/> Church <input type="checkbox"/> Other-Tax Exempt <input type="checkbox"/> Non-Profit <input type="checkbox"/> Government Entity
	<i>*S-Corp and LLC 2% or more owners and their family members are not eligible for 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.</i>
State Incorporated	
Divisions	<input type="checkbox"/> No <input type="checkbox"/> Yes, List divisions: If yes, is separate reporting needed for divisions? <input type="checkbox"/> No <input type="checkbox"/> Yes
Reporting Preferences	<input type="checkbox"/> Include Employee Names <input type="checkbox"/> Do not Include Employee Names <input type="checkbox"/> Email with Reports attached <input type="checkbox"/> Email to access Report in employer portal (Employee names not included) (Employee names can be included)
Payroll Provider	Provider Name:
	Feed Integration: <input type="checkbox"/> Enrollments <input type="checkbox"/> COBRA <input type="checkbox"/> HSA Contributions
Benefit Administration Platform	Provider Name:
	Feed Integration: <input type="checkbox"/> Enrollments <input type="checkbox"/> COBRA
Number of Employees	Total: Benefit Eligible:
Are you subject to FMLA?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Contact Information

Primary:	Title	Email
Phone #:	<input type="checkbox"/> Health Accounts <input type="checkbox"/> COBRA	Portal Access <input type="checkbox"/> Yes <input type="checkbox"/> No
Secondary:	Title	Email
Phone #:	<input type="checkbox"/> Health Accounts <input type="checkbox"/> COBRA	Portal Access <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional:	Title	Email
Phone #:	<input type="checkbox"/> Health Accounts <input type="checkbox"/> COBRA	Portal Access <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional:	Title	Email
Phone #:	<input type="checkbox"/> Health Accounts <input type="checkbox"/> COBRA	Portal Access <input type="checkbox"/> Yes <input type="checkbox"/> No
Additional:	Title	Email
Phone #:	<input type="checkbox"/> Health Accounts <input type="checkbox"/> COBRA	Portal Access <input type="checkbox"/> Yes <input type="checkbox"/> 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: Access to Portal?	<input type="checkbox"/> No <input type="checkbox"/> Yes, who:
Broker Contact Details – Name, Email, Phone:	
Broker	
Account Manager:	
Service Rep.:	

Additional Plan Information (Health Accounts)

Plan Identification	<input type="checkbox"/> COBRA <input type="checkbox"/> Health Reimbursement Arrangement (HRA) <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Flexible Spending Account (FSA) <input type="checkbox"/> Dependent Care Account (DCFSA) <input type="checkbox"/> Limited Purpose FSA (LPFSA) <i>(LPFSA is required if offering FSA and HSA)</i>			<input type="checkbox"/> Transportation <input type="checkbox"/> Parking <input type="checkbox"/> Tuition Reimbursement <input type="checkbox"/> Adoption reimbursement <input type="checkbox"/> Lifestyle Spending Account		
Live Date:						
Plan Year:						
Dates of Open Enrollment: <i>Estimated dates if not decided</i>						
Short Plan Year	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If short plan is FSA, proration of election is required)</i>					
Benefits Eligibility	Hours Worked Per Week (to qualify for benefits):	Waiting Period for New Hires:	When do terminated employee's benefits end?			
			<input type="checkbox"/> End of the month <input type="checkbox"/> Date of Termination			
Leave of Absence Policy	Can employees incur and submit new expenses during LOA?	Pause employer contributions during LOA?	Pause employee payroll deductions during LOA?			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Section 125: List your pre-tax benefits offered (medical, dental, vision, HSA, etc.):						
ERISA: If you have an existing plan, what is the current plan number and the original plan date:	Example: 501, 502, 503, 504...					
Payroll Frequency	If you have more than one payroll frequency, please select all.					
	<input type="checkbox"/> Weekly (52) <input type="checkbox"/> Bi-Weekly (26) <input type="checkbox"/> Bi-Weekly (24) <input type="checkbox"/> Semi Monthly (24) <input type="checkbox"/> Monthly (12) <input type="checkbox"/> Other _____					
What is the first payroll date within the plan year?			Note: Payroll deductions should be taken within the plan dates regardless of the pay period days worked.			

COBRA Administration (Informational Use) If Not Administered by Consumer Health Solutions

COBRA Administration	<input type="checkbox"/> TPA <input type="checkbox"/> In-House <input type="checkbox"/> Other**		
COBRA Provider	Name:		
	Address:		

Employer ACH Bank Account Setup

Use For: <i>Select All Those Applicable</i> <input type="checkbox"/> Reimbursements <input type="checkbox"/> Debit Card Funding <input type="checkbox"/> Billing <input type="checkbox"/> HSA Funding <input type="checkbox"/> COBRA <i>(Do not check if you want check reimbursement)</i>	Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings Routing Number: Account Number:
Bank Name:	
Bank Address:	
Additional Account	If a second bank account should be used for specific purposes or for a specific division (ex. COBRA or Billing):
	Use: Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings Routing Number: Account Number:
Does this bank account utilize positive pay to prevent deposits/withdrawals?	<input type="checkbox"/> No <input type="checkbox"/> Yes *If you responded yes: CHS can provide our bank information to be added as an authorized account to deposit and withdraw funds.

COBRA Premium Reimbursement by Mail

For Premium Reimbursement through check, please complete the following information. Do not complete this if you want COBRA premiums remitted by ACH.	
Pay to the Order of:	
Attention to:	
Mailing Address:	

Fees (As Established in Proposal)

Health Account Administration	Setup/Renewal Fee: As established in proposal Per Active Participant Per Month: As established in proposal
Debit Card	Initial Set of Debit Cards: \$0 Additional set of replacement cards: \$5 (charged to the participant unless otherwise indicated by employer)
Other fees where applicable:	Discrimination Testing Fee: \$150 Mid-year termination fee: \$300 plus one month's administration fee (termination prior to 30 days before the end of the plan's year) Mid-year plan change fee: Minimum of \$300 Outside administrator plan takeover: \$300 Pay the Provider HRA fee: \$15 / month Employee Navigator Fee: \$15 / month
COBRA	Ongoing Administration: 2% of premium billed per COBRA elected participant. (Collected from the participant) COBRA Monthly Administration Fee: Based on number of benefit eligible employees at the time of setup and recalculated annually at renewal. 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 \$300.***
- *Consumer Health Solutions will initialize the plans once the authorization page is provided.*

Company Name:

Authorizer Name:

Signature:

Date:

Flexible Spending Account Plan Design

Company Legal Name:			
Original Plan Effective Date:			
FSA Maximum	<input type="checkbox"/> Current IRS Limit <input type="checkbox"/> Other: \$ _____ <input type="checkbox"/> Not applicable, no FSA		
FSA Minimum Election	\$ _____		
FSA Employer Contribution:	\$ _____	Employer contributions allowed: <ul style="list-style-type: none"> • Flat rate up to \$500 • Match of the employee's contribution 	
Dependent Care FSA Maximum Election	<input type="checkbox"/> Current IRS Limit <input type="checkbox"/> Other: \$ _____ <input type="checkbox"/> Not applicable, no Dependent Care FSA		
Dependent Care FSA Minimum Election	\$ _____		
Employer Contribution:	\$ _____	Employer contributions cannot exceed the IRS limit.	
FSA: Rollover or Grace Period? Choose One: You cannot choose both Rollover and Grace period.	Rollover: IRS permits the carryover of funds into the next plan year Grace Period: Extra time after the plan ends to use FSA funds before they expire.		
	Rollover <input type="checkbox"/> Current IRS Limit <input type="checkbox"/> Other amount: \$ _____	Grace Period <input type="checkbox"/> 2 ½ Months <input type="checkbox"/> Other Length: _____	None <input type="checkbox"/> No Grace Period or Rollover
Dependent Care FSA Grace Period:	Grace Period <input type="checkbox"/> 2 ½ Months <input type="checkbox"/> Other Length: _____	None <input type="checkbox"/> No Grace Period	
Would you like a debit card for Dependent Care?	<input type="checkbox"/> No (Default) <input type="checkbox"/> Yes		
Run Out After Plan Year End:	<input type="checkbox"/> 90 Days (Default) <input type="checkbox"/> Other: _____		
Will CHS be administering the run-out for the previous FSA plan?	<input type="checkbox"/> No (Recommended) <input type="checkbox"/> Yes	If yes, additional cost will apply. CHS will need enrollments and balances from the prior administrator.	
Do you want to include the qualified reservist distribution in your plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes; If Yes, how you would you like disbursements calculated: <input type="checkbox"/> <i>Election minus reimbursements already paid</i> <input type="checkbox"/> <i>Contributions minus reimbursements already paid</i>		
	Qualified Reservist Distribution: 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.		
Notes	Other notes and rules for CHS team to be aware of:		

HRA Plan Design

Company Legal Name:		
Medical Carrier:		
Medical Plan Name(s) subject to the HRA, with group numbers:	<i>Please attach medical SBC</i>	
Do you have a separate group number for COBRA participants?	<input type="checkbox"/> No <input type="checkbox"/> Yes – Group Number:	
Is the Medical Plan HSA Qualified?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, will contributions be made to the HSA? (employee or employer?) <input type="checkbox"/> Yes <input type="checkbox"/> No</i>	
Effective Date of the HRA:		
Medical Plan Dates:		
Deductible Calculation Period:	<input type="checkbox"/> Plan Year Deductible <input type="checkbox"/> Calendar Year Deductible: January 1 – December 31*	Calendar Year Deductible: CHS will need Enrollments and a report of the claims paid from January through the new effective date
Current HRA in place?	<input type="checkbox"/> No <input type="checkbox"/> Yes, date first established:	HRA ERISA Plan #:
Will CHS be administering the runout period from the prior plan?	<input type="checkbox"/> No (Default) <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable	<i>If Yes: CHS will require enrollments, claims paid report, and account balance report. Additional fee applies for takeover of runout</i>
What is the runout period after the plan year end?	<input type="checkbox"/> 90 Days (Default) <input type="checkbox"/> Other:	<i>This is the amount of time the HRA will continue to pay for expenses incurred during the plan year.</i>
What is the terminated employee's runout?	<input type="checkbox"/> 90 Days (Default) <input type="checkbox"/> Other:	<i>This is the amount of time a terminated employee has to submit claims from when they were enrolled and eligible.</i>
How will claims be submitted to the HRA?	<input type="checkbox"/> Manual Claim Submission <input type="checkbox"/> File Feed with Medical Carrier: <input type="checkbox"/> Debit Card	Debit cards Limitation: <ul style="list-style-type: none"> Card cannot be used for specific expenses like deductible or copay. The card can only be set for categories of expenses (ex. Medical, Pharmacy, Dental, Vision). Card cannot track maximum reimbursement per member. HRA will be tracked Aggregately.
If debit card, will non-pharmacy expenses go through the card?	<input type="checkbox"/> Yes* <input type="checkbox"/> No <i>*If yes, please use notes section to list the eligible expenses on the card</i>	
Who are claims paid to?	<input type="checkbox"/> Member <input type="checkbox"/> Provider	Additional fees apply for Pay to the Provider HRA
What expenses are reimbursed under the HRA? Select all that apply	Medical: <input type="checkbox"/> Medical Deductible <input type="checkbox"/> Medical Copay <input type="checkbox"/> Medical Coinsurance <input type="checkbox"/> Rx Deductible <input type="checkbox"/> Rx Copay <input type="checkbox"/> Rx Coinsurance Other Options - Use notes section for specific details: <input type="checkbox"/> Dental <input type="checkbox"/> All 213(d) expenses <input type="checkbox"/> Other <input type="checkbox"/> Vision <input type="checkbox"/> Specific Copays	
When are HRA funds available to participants?	<input type="checkbox"/> Whole Amount Up Front (Beginning of Plan Year) (Default) <input type="checkbox"/> Other: If other, Are the funds Pro-Rated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the HRA have a carryover?	<input type="checkbox"/> No (Default) <input type="checkbox"/> Yes – Details:	
*S-Corp and LLC 2% or more owners and their immediate family members are not eligible for the HRA plan.	<i>Please Provide a list of any 2% or more owners (required) and provide the Subgroup number(s) for owners on the medical plan, if applicable to your plan.</i>	Carriers can create a subgroup number specifically for your owners. This helps CHS not pay owners or employees who are not eligible for the HRA.

HRA Plan Design Specifics - Additional Copies May Be Necessary

Medical Plan Name:	
Group Number:	

Is your Medical Plan an Embedded or Non-Embedded Deductible?
<input type="checkbox"/> Aggregate – one individual within a family may satisfy the family deductible. <input type="checkbox"/> Embedded – the deductible is capped at the single level per member. <input type="checkbox"/> Not Applicable (Ex. Dental/Vision)

	Medical Plan Deductible
Single	
Employee + 1	
Family	

	Medical Plan Out of Pocket Max
Single	
Employee + 1	
Family	

Will this HRA track family expenses individually per person or aggregately as a family? <i>Typically matches your medical plan</i>
<input type="checkbox"/> Aggregate Reimbursement - Any family member or combination of family members must meet the full employee responsibility before the HRA will pay any claims. <input type="checkbox"/> Tracked Per Individual (Embedded Reimbursement) - The underlying medical plan must be embedded to select this option. One family member must meet the individual responsibility before the HRA will pay any claims for that member. One family member can never meet the full family responsibility on their own or receive the full family reimbursement. There is a per member maximum for each family member. <input type="checkbox"/> Not Applicable (Ex. 213d) <input type="checkbox"/> Other:

Fill In ONE design that best fits your HRA.

2-level Cost Sharing	Who pays first: <input type="checkbox"/> HRA <input type="checkbox"/> Employee <input type="checkbox"/> Percentage:	Who pays second? <input type="checkbox"/> HRA <input type="checkbox"/> Employee <input type="checkbox"/> Percentage:
Single	\$	\$
Employee + 1	\$	\$
Family	\$	\$

3-level Cost Sharing	Who pays first: <input type="checkbox"/> HRA <input type="checkbox"/> Employee <input type="checkbox"/> Percentage:	Who pays second? <input type="checkbox"/> HRA <input type="checkbox"/> Employee <input type="checkbox"/> Percentage:	Who pays third? <input type="checkbox"/> HRA <input type="checkbox"/> Employee <input type="checkbox"/> Percentage:
Single	\$	\$	\$
Employee + 1	\$	\$	\$
Family	\$	\$	\$

Copayment – Employee and HRA Share the cost of specific expense. <i>Example, Employee responsible for \$40 of each copay on the medical plan, up to \$300.</i>	
Eligible Copays:	
Employee Pays: \$	HRA Pays: \$

Notes:

Please provide any additional necessary details:	
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Commuter Benefit Plans

Company Legal Name:		
Parking Plan Name:		
Transportation Plan Name:		
Original Effective Date:		
Pre-Tax: Parking Reimbursement Account	Monthly Minimum Election: \$ _____	
	Monthly Maximum Election: <input type="checkbox"/> \$ _____ OR <input type="checkbox"/> IRS Max	
	Employer Contribution: <input type="checkbox"/> \$ _____ OR <input type="checkbox"/> Match	
	Will you be offering the Debit Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you be offering a post-tax parking plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Minimum Election: \$ _____
Pre-Tax: Transportation Reimbursement Account	Monthly Minimum Election: \$ _____	
	Monthly Maximum Election: <input type="checkbox"/> \$ _____ OR <input type="checkbox"/> IRS Max	
	Employer Contribution: <input type="checkbox"/> \$ _____ OR <input type="checkbox"/> Match	
	Will you be offering the Debit Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you be offering a post-tax transportation plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Minimum Election: \$ _____
Run Out After Plan Year End	<input type="checkbox"/> 90 days (Default) <input type="checkbox"/> Other: _____	
When are funds available?	<input type="checkbox"/> On the payroll date (Default)	
	<input type="checkbox"/> 1 st of the Month regardless of payroll	
Notes	Other Notes and rules for CHS Team to be aware of:	

Health Savings Account

Employer Name:	
HSA Contribution File Notification	<input type="checkbox"/> Payroll File Feed <input type="checkbox"/> Direct ACH transfer from payroll to HSA <input type="checkbox"/> Self-Service in Employer Portal Payroll File Feed: Secure file sent from Payroll to CHS. CHS pulls funds from the employer bank account. Feed takes 1 day to 6 weeks to set up. Direct ACH: CHS provides the Account and Routing number for each employee enrolled. Employer enters the account information into payroll and funds transfer directly into the HSA. Self Service: Employer uploads one file per payroll date. CHS pulls funds from the employer bank account.
Will you be offering a Limited Purpose FSA?	<input type="checkbox"/> No <input type="checkbox"/> Yes - LPFSA is required if you offer FSA
Original Section 125 Plan Effective Date:	
Will the HSA have an employer contribution associated with it?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Employer Contribution (If Applicable)	What is the employer contribution to the HSA? Individual: \$ _____ Family: \$ _____
	When will the Employer Contribution be made? <input type="checkbox"/> Whole Amount Up Front <input type="checkbox"/> Pro-rated Quarterly <input type="checkbox"/> Pro-rated Per Payroll <input type="checkbox"/> Other <input type="checkbox"/> Pro-rated Monthly
Additional Contribution Information:	

Health Savings Account Fees

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 First of Every Month	Consumer after Termination	\$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

COBRA Information

Company Legal Name:		
Which plans are eligible for COBRA:	<input type="checkbox"/> Medical # of Plans: <input type="checkbox"/> Dental # of Plans: <input type="checkbox"/> Vision # of Plans: <input type="checkbox"/> Rx Standalone: <input type="checkbox"/> FSA <input type="checkbox"/> HRA <input type="checkbox"/> EAP <input type="checkbox"/> Other:	
Live date for COBRA administration with CHS:		
Current COBRA Administration:	<input type="checkbox"/> Self-administered <input type="checkbox"/> Cobra Vendor - Name of Current Administrator:	
Are there specific divisions for COBRA?	<input type="checkbox"/> No <input type="checkbox"/> Yes, please list:	
# of Participants Enrolled in COBRA:		<i>If you have any participants enrolled in cobra or pending participants, please complete the COBRA takeover census.</i>
# of Pending COBRA Participants:		
# of Employees enrolled in a COBRA Eligible Plans:		
Do you need Open Enrollment notices sent to existing QBs?	<input type="checkbox"/> No* <i>default</i> <input type="checkbox"/> Yes, dates of open enrollment:	
Are there any ongoing carrier issues to be aware of? <i>Ex. Outdated termination appeal</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:	
Are you subject to State Continuation?	<input type="checkbox"/> No <input type="checkbox"/> Yes, please list the state(s):	
Do you want to be notified of every carrier coverage change per person per plan?	<p>Please note: This notification is one email per line of coverage per subscriber</p> <p>Please consider your size prior to making a choice. You will be notified of each month's remittance.</p> <input type="checkbox"/> No (Default) <input type="checkbox"/> Yes	

Medical Plan Information

Medical Plan 1		
Carrier Name:		
Plan Name:		
Plan Type:		
Plan Policy ID:		
Available for what divisions:	<input type="checkbox"/> All <input type="checkbox"/> Specify which divisions:	
Insured:	<input type="checkbox"/> Fully Insured <input type="checkbox"/> Self-Insured	
Carrier Account Management Contact:	Name: Email Address: Phone Number:	
Has carrier been notified of CHS as the COBRA vendor?	<input type="checkbox"/> Yes	
Plan Year Dates:		
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month	
Is this plan bundled with another plan?	<input type="checkbox"/> Yes, Indicate what plan: <input type="checkbox"/> No	
Conversion to Individual Plan allowed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a new plan or renewing plan?	<input type="checkbox"/> Renewing Plan <input type="checkbox"/> New Plan - This plan replaces:	
For age banded rates, when do premiums change?	<input type="checkbox"/> Enrollment Date <input type="checkbox"/> Birthday <input type="checkbox"/> Plan Renewal Date	
Premium Rates	Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	
	Premium Level	Composite Premium Amount
	Employee Only	\$
	Employee + Spouse	\$
	Employee + Child	\$
	Employee + Children <i>(Only If different from EE + Child)</i>	\$
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:		
Plan Policy ID:		
Available for what divisions:	<input type="checkbox"/> All <input type="checkbox"/> Specify which divisions:	
Insured:	<input type="checkbox"/> Fully Insured <input type="checkbox"/> Self-Insured	
Carrier Account Management Contact:	Name: Email Address: Phone Number:	
Has carrier been notified of CHS as the COBRA vendor?	<input type="checkbox"/> Yes	
Plan Year Dates:		
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month	
Is this plan bundled with another plan?	<input type="checkbox"/> Yes, Indicate what plan: <input type="checkbox"/> No	
Conversion to Individual Plan allowed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a new plan or renewing plan?	<input type="checkbox"/> Renewing Plan <input type="checkbox"/> New Plan - This plan replaces:	
For age banded rates, when do premiums change?	<input type="checkbox"/> Enrollment Date <input type="checkbox"/> Birthday <input type="checkbox"/> Plan Renewal Date	
Premium Rates	Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	
	Premium Level	Composite Premium Amount
	Employee Only	\$
	Employee + Spouse	\$
	Employee + Child	\$
	Employee + Children <i>(Only If different from EE + Child)</i>	\$
Employee + Family	\$	
If Rates are age banded or otherwise non-composite, please attach the rate information separately.		

Vision Plan Information:

Vision Plan 1		
Carrier Name:		
Plan Name:		
Plan Type:		
Plan Policy ID:		
Available for what divisions:	<input type="checkbox"/> All <input type="checkbox"/> Specify which divisions:	
Insured:	<input type="checkbox"/> Fully Insured <input type="checkbox"/> Self-Insured	
Carrier Account Management Contact:	Name: Email Address: Phone Number:	
Has carrier been notified of CHS as the COBRA vendor?	<input type="checkbox"/> Yes	
Plan Year Dates:		
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month	
Is this plan bundled with another plan?	<input type="checkbox"/> Yes, Indicate what plan: <input type="checkbox"/> No	
Conversion to Individual Plan allowed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a new plan or renewing plan?	<input type="checkbox"/> Renewing Plan <input type="checkbox"/> New Plan - This plan replaces:	
For age banded rates, when do premiums change?	<input type="checkbox"/> Enrollment Date <input type="checkbox"/> Birthday <input type="checkbox"/> Plan Renewal Date	
Premium Rates	Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	
	Premium Level	Composite Premium Amount
	Employee Only	\$
	Employee + Spouse	\$
	Employee + Child	\$
	Employee + Children <i>(Only If different from EE + Child)</i>	\$
Employee + Family	\$	
If Rates are age banded or otherwise non-composite, please attach the rate information separately.		

HRA (If Applicable)

Administrator Name:	
Administrator Contact Information <i>Note: Self-administered HRA's are subject to COBRA</i>	Name: Email Address: Phone Number:
Applies To:	<input type="checkbox"/> All available medical plans <input type="checkbox"/> Specific medical plans: <input type="checkbox"/> HRA is tied to a non-medical plan:
Are Cobra participants allowed to elect the medical insurance plan WITHOUT the HRA?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Participation in this medical plan automatically includes participation in the HRA
Plan Year Dates	
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month
HRA Rates: <i>*HRA rates must be provided by the employer. Calculation assistance is outlined below.</i>	Employee Only:
	Employee + Spouse:
	Employee + Child:
	Employee + Children: (Only If different from EE + Child)
	Employee + Family:
Past Cost HRA Premium Calculation Method	
Eligibility Note	
The HRA must have been in force for a minimum of 12 months without material plan design changes that could significantly impact utilization.	
Required Information	
<ul style="list-style-type: none"> • Prior plan year utilization rate (Current plan year, if effective date is in the future) <i>(Total reimbursements paid ÷ total HRA exposure)</i> • Current plan year reimbursement maximums by coverage tier (New plan year, if the effective date is in the future) <i>(e.g., single, employee + spouse, family)</i> 	
Calculation Method	
For each coverage tier, the estimated monthly HRA premium is calculated as:	
<i>(Utilization Rate × Reimbursement Maximum for the Coverage Tier) ÷ 12</i>	
For further information on HRA premium calculation please refer to § 4980B(f)(4)(A) of the IRS Code.	

FSA (If Applicable)

Administrator Name:	
Carrier Contact Information	Name: Email Address: Phone Number:
Plan Name:	
Plan Year Dates	
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month
FSA Renewal Month:	

Other Plan Offerings

Additional Plan		
Carrier Name:		
Plan Name:		
Plan Type:		
Plan Policy ID:		
Available for what divisions:	<input type="checkbox"/> All <input type="checkbox"/> Specify which divisions:	
Insured:	<input type="checkbox"/> Fully Insured <input type="checkbox"/> Self-Insured	
Carrier Account Management Contact:	Name: Email Address: Phone Number:	
Has carrier been notified of CHS as the COBRA vendor?	<input type="checkbox"/> Yes	
Plan Year Dates:		
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month	
Is this plan bundled with another plan?	<input type="checkbox"/> Yes, Indicate what plan: <input type="checkbox"/> No	
Conversion to Individual Plan allowed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a new plan or renewing plan?	<input type="checkbox"/> Renewing Plan <input type="checkbox"/> New Plan - This plan replaces:	
For age banded rates, when do premiums change?	<input type="checkbox"/> Enrollment Date <input type="checkbox"/> Birthday <input type="checkbox"/> Plan Renewal Date	
Premium Rates	Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	
	Premium Level	Composite Premium Amount
	Employee Only	\$
	Employee + Spouse	\$
	Employee + Child	\$
	Employee + Children <i>(Only If different from EE + Child)</i>	\$
Employee + Family	\$	
If Rates are age banded or otherwise non-composite, please attach the rate information separately.		

Other Plan Offerings

Additional Plan		
Carrier Name:		
Plan Name:		
Plan Type:		
Plan Policy ID:		
Available for what divisions:	<input type="checkbox"/> All <input type="checkbox"/> Specify which divisions:	
Insured:	<input type="checkbox"/> Fully Insured <input type="checkbox"/> Self-Insured	
Carrier Account Management Contact:	Name: Email Address: Phone Number:	
Has carrier been notified of CHS as the COBRA vendor?	<input type="checkbox"/> Yes	
Plan Year Dates:		
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month	
Is this plan bundled with another plan?	<input type="checkbox"/> Yes, Indicate what plan: <input type="checkbox"/> No	
Conversion to Individual Plan allowed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a new plan or renewing plan?	<input type="checkbox"/> Renewing Plan <input type="checkbox"/> New Plan - This plan replaces:	
For age banded rates, when do premiums change?	<input type="checkbox"/> Enrollment Date <input type="checkbox"/> Birthday <input type="checkbox"/> Plan Renewal Date	
Premium Rates	Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	
	Premium Level	Composite Premium Amount
	Employee Only	\$
	Employee + Spouse	\$
	Employee + Child	\$
	Employee + Children <i>(Only If different from EE + Child)</i>	\$
Employee + Family	\$	
If Rates are age banded or otherwise non-composite, please attach the rate information separately.		

Other Plan Offerings

Additional Plan		
Carrier Name:		
Plan Name:		
Plan Type:		
Plan Policy ID:		
Available for what divisions:	<input type="checkbox"/> All <input type="checkbox"/> Specify which divisions:	
Insured:	<input type="checkbox"/> Fully Insured <input type="checkbox"/> Self-Insured	
Carrier Account Management Contact:	Name: Email Address: Phone Number:	
Has carrier been notified of CHS as the COBRA vendor?	<input type="checkbox"/> Yes	
Plan Year Dates:		
Coverage End Date:	<input type="checkbox"/> Event Date <input type="checkbox"/> End of Month	
Is this plan bundled with another plan?	<input type="checkbox"/> Yes, Indicate what plan: <input type="checkbox"/> No	
Conversion to Individual Plan allowed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a new plan or renewing plan?	<input type="checkbox"/> Renewing Plan <input type="checkbox"/> New Plan - This plan replaces:	
For age banded rates, when do premiums change?	<input type="checkbox"/> Enrollment Date <input type="checkbox"/> Birthday <input type="checkbox"/> Plan Renewal Date	
Premium Rates	Enter Monthly COBRA Premiums: (do not include the 2% admin fee)	
	Premium Level	Composite Premium Amount
	Employee Only	\$
	Employee + Spouse	\$
	Employee + Child	\$
	Employee + Children <i>(Only If different from EE + Child)</i>	\$
	Employee + Family	\$
If Rates are age banded or otherwise non-composite, please attach the rate information separately.		