Consumer Health Solutions TPA Setup for: 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: HScafidi@consumerhealthsolutions

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

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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.

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:

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.

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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.

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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:			

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	$_____

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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) **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:
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