



## COBRA Benefit Rate Renewal

**Please note:** All COBRA participants have the same rights as active employees have during open enrollment and have the same options to switch benefit plans. Please notify HRC Total Solutions if you would like us to send out Open Enrollment materials to all COBRA participants. Please refer to your service agreement for the cost to send these packets to current and pending participants.

Please have the rate update form into our office **10 business days** prior to the rate change to guarantee the new rates will be processed by the effective date provided. If the rates are not received within this time frame, HRCTS cannot guarantee the rates will be processed before the rate change occurs. HRCTS will process the new rates as quickly as possible but will not be responsible for any deficit that might be incurred due to this rate change.

**If rates are processed after the effective date provided, and your company has COBRA Participants actively enrolled in COBRA, it will need to be communicated to us which of the following options you would like:**

1. COBRA participants to be responsible for the retro rate charge.
2. Add a subsidy for the difference in the rates. There could be a fee for HRCTS to add the Subsidy.
  - You are able to add the Subsidy through the Employer COBRA Portal.

### Part I. Employer Information

Employer Name: \_\_\_\_\_

Point of Contact: \_\_\_\_\_ Phone Ext: \_\_\_\_\_ Email: \_\_\_\_\_

Please confirm below, who will send out open enrollment materials to enrolled and pending COBRA Participants.

Employer	HRCTS
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### Part II. Benefit Plan Description: Please include **ALL** plans even if there is no change in rates.

Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_ Medical      Dental      Vision

Effective Date: \_\_\_\_\_ Group #: \_\_\_\_\_ Coverage Terminates: \_\_\_\_\_ Event Date      End of Month

*(Event date = coverage begins day after term date. End of month = coverage starts the 1st of month following the term date)*

Is this a new plan      Yes      No      If yes, what plan will it be replacing? Plan: \_\_\_\_\_ Group # \_\_\_\_\_

If this is a new plan or contact info change please provide carrier contact information below.

Please enroll via:	web	fax	e-mail	Fax#/ E-mail _____
	Current Premium			COBRA Premium
EE Only	\$ _____	( + 2% Administration Fee) =	\$ _____	\$ _____
EE + Spouse	\$ _____	( + 2% Administration Fee) =	\$ _____	\$ _____
EE + Child	\$ _____	( + 2% Administration Fee) =	\$ _____	\$ _____
EE + Children	\$ _____	( + 2% Administration Fee) =	\$ _____	\$ _____
EE + Family	\$ _____	( + 2% Administration Fee) =	\$ _____	\$ _____

**Part II. Benefit Plan Description (Continued)**

Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_ Medical Dental Vision  
 Effective Date: \_\_\_\_\_ Group #: \_\_\_\_\_ Coverage Terminates: \_\_\_\_\_ Event Date End of Month

*(Event date = coverage begins day after term date. End of month = coverage starts the 1st of month following the term date)*

Is this a new plan Yes No If yes, what plan will it be replacing? Plan: \_\_\_\_\_ Group # \_\_\_\_\_

If this is a new plan or contact info change please provide carrier contact information below.

Please enroll via: web fax e-mail Fax#/ E-mail \_\_\_\_\_

	Current Premium		COBRA Premium
EE Only	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Spouse	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Child	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Children	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Family	\$ _____	( + 2% Administration Fee) =	\$ _____

Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_ Medical Dental Vision  
 Effective Date: \_\_\_\_\_ Group #: \_\_\_\_\_ Coverage Terminates: \_\_\_\_\_ Event Date End of Month

*(Event date = coverage begins day after term date. End of month = coverage starts the 1st of month following the term date)*

Is this a new plan Yes No If yes, what plan will it be replacing? Plan: \_\_\_\_\_ Group # \_\_\_\_\_

If this is a new plan or contact info change please provide carrier contact information below.

Please enroll via: web fax e-mail Fax#/ E-mail \_\_\_\_\_

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EE + Child	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Children	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Family	\$ _____	( + 2% Administration Fee) =	\$ _____

Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_ Medical Dental Vision  
 Effective Date: \_\_\_\_\_ Group #: \_\_\_\_\_ Coverage Terminates: \_\_\_\_\_ Event Date End of Month

*(Event date = coverage begins day after term date. End of month = coverage starts the 1st of month following the term date)*

Is this a new plan Yes No If yes, what plan will it be replacing? Plan: \_\_\_\_\_ Group # \_\_\_\_\_

If this is a new plan or contact info change please provide carrier contact information below.

Please enroll via: web fax e-mail Fax#/ E-mail \_\_\_\_\_

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EE + Child	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Children	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Family	\$ _____	( + 2% Administration Fee) =	\$ _____



# HRC TOTAL SOLUTIONS

**Health Care Reimbursement Arrangement Vendor (HRA):** \_\_\_\_\_ Renewal date: \_\_\_\_\_

If vendor other than HRCTS - Please enroll via:    web    fax    e-mail    Fax#/ E-mail \_\_\_\_\_

What type of HRA Plan/s do you have:    Integrated (Paired with a medical plan)    standalone HRA plan

If standalone HRA plan, which type of standalone HRA plan do you have:    Wellness    Dental    Vision

(Please check all that apply)

If Applicable, please specify below all Medical plans that are paired with an HRA plan.

Plan/group # with HRA \_\_\_\_\_ Plan/group # w/out HRA \_\_\_\_\_

Plan/group # with HRA \_\_\_\_\_ Plan/group # w/out HRA \_\_\_\_\_

Plan/group # with HRA \_\_\_\_\_ Plan/group # w/out HRA \_\_\_\_\_

Are you charging for this HRA plan:    YES    NO    If, yes, please provide the monthly rates below

*(If no, please note, COBRA Participants could enroll in this plan at no charge.)*

	Current Premium		COBRA Premium
EE Only	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Spouse	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Child	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Children	\$ _____	( + 2% Administration Fee) =	\$ _____
EE + Family	\$ _____	( + 2% Administration Fee) =	\$ _____

**Healthcare Flexible Spending Account Vendor(FSA):** \_\_\_\_\_ Renewal Date \_\_\_\_\_

FSA Coverage terminates:    Event date    End of month

If vendor other than HRCTS - Please enroll via:    web    fax    e-mail    Fax#/ E-mail \_\_\_\_\_

### Part III. Signature

Authorized Signature of Employer: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_