HRC TOTAL SOLUTIONS

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

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) =	$_____

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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.

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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

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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 # _____

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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: _____