HRC TOTAL SOLUTIONS
FSA·HRA·HSA·COMMUTER·COBRA·LSA·ICHRA

COBRA BENEFIT RATE RENEWAL

Please note: All COBRA participants have the same rights that active employees have during open enrollment and have the same options to switch benefit plans. Please notify HRC if you would like us to send out Open Enrollment materials to 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, HRC cannot guarantee the rates will be processed before the rate change occurs. HRC 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, 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 HRC to add the Subsidy. You are able to add the Subsidy through the Employer COBRA Portal.

I. Employer Information

Employer Name:		
Point of Contact:	Phone:	Email:
Who will be sending out Open Enrollment materials to enrolled and pending participants*?* ☐ Employer ☐ HRC		

II. Health Reimbursement Arrangement (HRA)

Vendor:	Renewal Date:
What type of HRA plan/s do you have? ☐ Integrated (paired with a medical plan) ☐ Standalone **If a standalone plan, what type of plan design do you have? ☐ Wellness ☐ Dental ☐ Vision	
If applicable, please specify below all medical plans that are paired with an HRA plan.	
Plan Group # with HRA:	*Plan/Group # without HRA:*
Plan Group # with HRA:	*Plan/Group # without HRA:*
Plan Group # with HRA:	*Plan/Group # without HRA:*
Are you charging the participant for this HRA plan? ☐ Yes ☐ No ***If yes, please provide the monthly premium rates for this plan below. If no, please note COBRA participants could enroll in this plan at no charge.*	

Coverage Premiums			
Current Monthly Premium		COBRA Premium (Monthly Premium + 2% Administration Fee)	
Individual	$	*Individual*	$
EE + Spouse	$	*EE + Spouse*	$
EE + Child	$	*EE + Child*	$
EE + Children	$	*EE + Children*	$
Family	$	*Family*	$

III. Healthcare Flexible Spending Account (FSA)

Vendor:	Renewal Date:
Coverage Terminates: ☐ Event Date ☐ End of Month *Event Date = Coverage begins the day after the termination date.* *End of Month = Coverage starts the 1st of the month following the termination date.*	

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IV. Benefit Plan Description: Please include ALL plans even if there is no change in rates.

Please note: *if your medical plan has a carved-out RX benefit with a different RX vendor than your health insurance carrier; please list the RX vendor separately.*

Plan Type ☐ Medical ☐ Dental ☐ Vision	
Insurance Carrier:	
Plan Name:	Group #
Effective Date:	
Coverage Terminates: ☐ Event Date ☐ End of Month *(Event date = Coverage begins day after termination date. End of month = Coverage starts the 1st of month following the termination date)*	
Is this a new plan?	☐ Yes ☐ No
***If yes, is this plan replacing an existing plan?*	☐ Yes ☐ No
***If yes, which plan is this plan replacing?*	
Plan Name:	Group #:
Coverage Premiums	
Current Monthly Premium	**COBRA Premium (Monthly Premium + 2% Administration Fee)**
Individual $	*Individual* $
EE + Spouse $	*EE + Spouse* $
EE + Child $	*EE + Child* $
EE + Children $	*EE + Children* $
Family $	*Family* $

Plan Type ☐ Medical ☐ Dental ☐ Vision	
Insurance Carrier:	
Plan Name:	Group #
Effective Date:	
Coverage Terminates: ☐ Event Date ☐ End of Month *(Event date = Coverage begins day after termination date. End of month = Coverage starts the 1st of month following the termination date)*	
Is this a new plan?	☐ Yes ☐ No
***If yes, is this plan replacing an existing plan?*	☐ Yes ☐ No
***If yes, which plan is this plan replacing?*	
Plan Name:	Group #:
Coverage Premiums	
Current Monthly Premium	**COBRA Premium (Monthly Premium + 2% Administration Fee)**
Individual $	*Individual* $
EE + Spouse $	*EE + Spouse* $
EE + Child $	*EE + Child* $
EE + Children $	*EE + Children* $
Family $	*Family* $

If additional space is needed please copy this page and include when submitting your rates.

Plan Type ☐ Medical ☐ Dental ☐ Vision	
Insurance Carrier:	
Plan Name:	Group #
Effective Date:	
Coverage Terminates: ☐ Event Date ☐ End of Month *(Event date = Coverage begins day after termination date. End of month = Coverage starts the 1st of month following the termination date)*	
Is this a new plan?	☐ Yes ☐ No
***If yes, is this plan replacing an existing plan?*	☐ Yes ☐ No
***If yes, which plan is this plan replacing?*	
Plan Name:	Group #:

Coverage Premiums			
Current Monthly Premium		COBRA Premium (Monthly Premium + 2% Administration Fee)	
Individual	$	*Individual*	$
EE + Spouse	$	*EE + Spouse*	$
EE + Child	$	*EE + Child*	$
EE + Children	$	*EE + Children*	$
Family	$	*Family*	$

V. Authorized Signatures

Name:	Title:
Signature:	Date: