



## 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 Total Solutions 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 timeframe, 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, 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.

### I. Employer Information

Employer Name:		
Point of Contact:	Phone:	Email:
Who will be sending out Open Enrollment materials to enrolled and pending participants?		
<input type="checkbox"/> Employer <input type="checkbox"/> HRCTS		

### II. Health Reimbursement Arrangement (HRA)

Vendor:	Renewal Date:		
What type of HRA plan/s do you have? <input type="checkbox"/> Integrated (paired with a medical plan) <input type="checkbox"/> Standalone <b>**If a standalone plan, what type of plan design do you have?</b> <input type="checkbox"/> Wellness <input type="checkbox"/> Dental <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>**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.</b>			
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: <input type="checkbox"/> Event Date <input type="checkbox"/> End of Month <i>Event Date = Coverage begins the day after the termination date.</i> <i>End of Month = Coverage starts the 1<sup>st</sup> of the month following the termination date.</i>	

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

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

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

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

