HRC TOTAL SOLUTIONS

COBRA Employer Application

Part I. Employer Information

Employer Name: _____

Mailing Address:_____ City:_____ State: _____Zip:_____

Street Address (If Different): _____ City:_____ State:_____ Zip: _____

Phone #:_____ Fax: _____ Tax ID #: _____

Primary Point of Contact: _____ Phone Ext:_____ Email: _____

Secondary Point of Contact: _____ Phone Ext:_____ Email: _____

Billing Point of Contact: _____ Phone Ext: _____Email:_____

Effective Date of COBRA Administration:_____ Total Number of Employees: _____

Total number of active COBRA Participants_____ Total number of pending COBRA Participants _____

Please provide all divisions that will be listed under this company:_____

_____

* Please note: when setting up divisions, you will receive 1 monthly remittance check as well as 1 remittance report listing all divisions and COBRA Participants accordingly.

Part II. Fees

Broker:

Setup Fee:$_____ Monthly Maintenance Fee:$_____ Takeover Notification Fee:$_____

Please select one of the following options. For further details please contact HRC Total Solutions

◯ Per Eligible Employee Option _____ PEPM $15 Minimum Billing Per Month

◯ Per Notification Option _____ General Rights Letter _____ Specific Rights Letter

_____ Open Enrollment Packet

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

◯ Employer ◯ HRCTS ◯ Former COBRA Administrator

Comments:_____

_____

(2% admin fee paid by participant is retained by HRCTS)

Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrcts.com • www.HRCTS.com • 111 Charles Street • Manchester, NH 03101

Part III. Plan Description

A. Carrier:_____ Plan Name:_____ ◯ Medical ◯ Dental ◯ Vision

Renewal 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)

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) =	$_____

B. Carrier:_____ Plan Name:_____ ◯ Medical ◯ Dental ◯ Vision

Renewal 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)

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) =	$_____

C. Carrier:_____ Plan Name:_____ ◯ Medical ◯ Dental ◯ Vision

Renewal 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)

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) =	$_____

HRC TOTAL SOLUTIONS

Part III. Continued

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 Plans 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. (please make the lies as long as they can go, each!)

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 _____

***Please Note:**

Open Enrollment: During your companies open enrollment period you will need to notify all pending and current COBRA Participants of ALL open enrollment options as they have the same rights as active employees. Please notify HRC Total Solutions if you would like us to send out your 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.

Rates: Rates will need to be communicated to HRCTS as soon as you have them. Participants should be notified in advance of rates changes. 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.

Part IV. Signature

Authorized Signature of Employer: _____ Title: _____ Date: _____

Internal Comments **BPF:** **S** **R** **GRL** **SRL**

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