Your COBRA Connection
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Portage, MI 49081-1983
Telephone 269-220-5710 • Fax 269-220-5711
info@yourcobraconnection.com

CLIENT COMPANY INFORMATION SHEET and PLAN RENEWAL INFORMATION

EMPLOYER INFORMATION Date Completed: _____

Legal Company Name: _____

DBA/AKA: _____

Mailing Address: _____

City, State, Zip: _____

Physical Mailing Address (if different): _____

City, State, Zip: _____

Main Telephone: _____ Fax: _____

Website: _____

Number of employees covered by a group health plan: _____

EMPLOYER CONTACT INFORMATION

Company Officer Name: _____

Title: _____ Phone: _____Ext: _____

Email Address: _____

HR/Benefits Contact Name: _____

Title: _____ Phone: _____Ext: _____

Email Address: _____

Billing Contact Name: _____

Title: _____ Phone: _____Ext: _____

Email Address: _____

Invoices sent to mailing or physical address: _____

Invoices can be sent via email? _____ Yes _____ No

GROUP HEALTH PLANS SUBJECT TO THE CONTINUATION COVERAGE REQUIREMENTS

COBRA applies to those employers that "maintain" a "group health plan" that provides "medical care."

"Maintain" - according to the regulations, an employer maintains a plan even if they do not contribute to the cost of the plan. Key issues will be if the employee is eligible to participate in the plan through his or her association with the employer, and second, would the plan be available to the employee at the same cost if the employee was no longer associated with the employer.

"Group Health Plan" - includes any plan that is provided to the employer's employees, former employees, or the families of such employees, through insurance or "otherwise." This includes many forms of arrangements such as insured plans, self-funded plans, and informal employer/employee arrangements.

"Medical Care" - a broad definition that covers the "diagnosis, cure, mitigation, treatment or prevention of disease."

- Major medical plans
- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Dental plans
- Vision plans
- Prescription drug plans
- Employee Assistance Programs
- Flexible Spending Accounts
- Health Reimbursement Arrangements
- Mental health plans
- Self funded health plans
- Section 125 plans

Flexible Spending Accounts (FSAs) and Health Reimbursement Arrangements (HRAs) are considered group health plans under the law and need to be listed on the group health plan sheets.

Individual Policies: Insurance also includes one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees.

Noncontributory Health Plans: A group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to the cost of the insurance, meaning it is totally funded by the employee. This applies if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization.

Drug or alcohol treatment program or a health clinic: If an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.

Employee Assistance Programs (EAP) An EAP is designed to help employers address productivity issues by assisting employees in identifying and resolving personal concerns. Normally these services are provided through counseling, information and referral services. These concerns include, but are not limited to: mental and behavioral health issues, alcohol and substance abuse, eating disorders, stress or other personal issues that may affect job performance.

By the above definition of medical care, many of the services provided by an EAP would be considered medical care. Therefore, EAPs that cover these types of services are considered to be a group health plan subject to the continuation coverage rules of COBRA. A failure to offer EAP continuation coverage when a qualifying event occurs would be considered a violation of the law.

IF ANY PLAN IS AGE RATED YOU MUST PROVIDE A COPY OF THE AGE BRACKETS!

PLAN ONE
HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Policy Effective Date: _____ Policy Renewal Date: _____

Type of Insurance Plan: _____
(Example: Medical, Dental, Vision, HRA, EAP, FSA, etc.)

Benefits/Coverage Terminate: _____ Day of the event _____ End of the month

Is the plan bundled with any other health plan? ____ Yes ____ No If yes, what plan? _____

RATES renew on what date? _____

Please enter all rates even if no one is currently enrolled in that level of coverage. **LIST THE FULL MONTHLY PREMIUM CHARGED BY THE INSURANCE CARRIER**! Do NOT include the 2% admin fee.)*

Single _____

Married Couple _____

EE Plus Children _____

Family _____

* These are the most common rate tiers. If you have more rate tiers than listed, please provide a complete breakdown of the rates along with this informational sheet. If age rated, please provide the breakdown.

PLAN TWO
HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Policy Effective Date: _____ Policy Renewal Date: _____

Type of Insurance Plan: _____
(Example: Medical, Dental, Vision, HRA, EAP, FSA, etc.)

Benefits/Coverage Terminate: _____ Day of the event _____ End of the month

Is the plan bundled with any other health plan? ____ Yes ____ No If yes, what plan? _____

RATES renew on what date? _____

Please enter all rates even if no one is currently enrolled in that level of coverage. **LIST THE FULL MONTHLY PREMIUM CHARGED BY THE INSURANCE CARRIER**! Do NOT include the 2% admin fee.)*

Single _____

Married Couple _____

EE Plus Children _____

Family _____

* These are the most common rate tiers. If you have more rate tiers than listed, please provide a complete breakdown of the rates along with this informational sheet. If age rated, please provide the breakdown.

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PLAN THREE
HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Policy Effective Date: _____ Policy Renewal Date: _____

Type of Insurance Plan: _____
(Example: Medical, Dental, Vision, HRA, EAP, FSA, etc.)

Benefits/Coverage Terminate: _____ Day of the event _____ End of the month

Is the plan bundled with any other health plan? ____ Yes ____ No If yes, what plan? _____

RATES renew on what date? _____

Please enter all rates even if no one is currently enrolled in that level of coverage. **LIST THE FULL MONTHLY PREMIUM CHARGED BY THE INSURANCE CARRIER**! Do NOT include the 2% admin fee.)*

Single _____

Married Couple _____

EE Plus Children _____

Family _____

* These are the most common rate tiers. If you have more rate tiers than listed, please provide a complete breakdown of the rates along with this informational sheet. If age rated, please provide the breakdown.

PLAN FOUR
HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Policy Effective Date: _____ Policy Renewal Date: _____

Type of Insurance Plan: _____
(Example: Medical, Dental, Vision, HRA, EAP, FSA, etc.)

Benefits/Coverage Terminate: _____ Day of the event _____ End of the month

Is the plan bundled with any other health plan? ____ Yes ____ No If yes, what plan? _____

RATES renew on what date? _____

Please enter all rates even if no one is currently enrolled in that level of coverage. **LIST THE FULL MONTHLY PREMIUM CHARGED BY THE INSURANCE CARRIER**! Do NOT include the 2% admin fee.)*

Single _____

Married Couple _____

EE Plus Children _____

Family _____

* These are the most common rate tiers. If you have more rate tiers than listed, please provide a complete breakdown of the rates along with this informational sheet. If age rated, please provide the breakdown.

IF ANY PLAN IS AGE RATED YOU MUST PROVIDE A COPY OF THE AGE BRACKETS!

PLAN FIVE
HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Policy Effective Date: _____ Policy Renewal Date: _____

Type of Insurance Plan: _____
(Example: Medical, Dental, Vision, HRA, EAP, FSA, etc.)

Benefits/Coverage Terminate: _____ Day of the event _____ End of the month

Is the plan bundled with any other health plan? ____ Yes ____ No If yes, what plan? _____

RATES renew on what date? _____

Please enter all rates even if no one is currently enrolled in that level of coverage. **LIST THE FULL MONTHLY PREMIUM CHARGED BY THE INSURANCE CARRIER**! Do NOT include the 2% admin fee.)*

Single _____

Married Couple _____

EE Plus Children _____

Family _____

* These are the most common rate tiers. If you have more rate tiers than listed, please provide a complete breakdown of the rates along with this informational sheet. If age rated, please provide the breakdown.

PLAN SIX
HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Policy Effective Date: _____ Policy Renewal Date: _____

Type of Insurance Plan: _____
(Example: Medical, Dental, Vision, HRA, EAP, FSA, etc.)

Benefits/Coverage Terminate: _____ Day of the event _____ End of the month

Is the plan bundled with any other health plan? ____ Yes ____ No If yes, what plan? _____

RATES renew on what date? _____

Please enter all rates even if no one is currently enrolled in that level of coverage. **LIST THE FULL MONTHLY PREMIUM CHARGED BY THE INSURANCE CARRIER**! Do NOT include the 2% admin fee.)*

Single _____

Married Couple _____

EE Plus Children _____

Family _____

* These are the most common rate tiers. If you have more rate tiers than listed, please provide a complete breakdown of the rates along with this informational sheet. If age rated, please provide the breakdown.