IMPLEMENTATION WORKSHEET
COBRA

COMPANY INFORMATION

Company Name ____________________

Tax ID Number (EIN) ____________________

Address ____________________

City, State, ZIP ____________________

Number of Eligible Employees: ____________________

Have initial notices been sent to the eligible individuals? ☐ Yes ☐ No

If no, do you want Surency to send notices? ☐ Yes ☐ No *(Please note: additional fees may apply)*

Do you have multiple division/locations? ☐ Yes, please list below ☐ No

COMPANY CONTACTS

Name ____________________

Title ____________________

Email ____________________

Phone ____________________

Employer Portal Access? ☐ Yes ☐ No *(If yes, please complete the Employer Account Registration Form on pg. 9)*

If billing contact is different from the information above, please provide below.

Billing Contact ____________________

Email ____________________

Address ____________________

City, State, ZIP ____________________

Billing Preference: ☐ Paper ☐ E-Bill *(If E-Bill, please complete the Bills Account Registration Form on pg. 10)*

BROKER INFORMATION

Agency Name ____________________

Agent Name ____________________

Broker # ____________________

Email ____________________

Address ____________________

City, State, ZIP ____________________

Phone ____________________

Employer Portal Access? ☐ Yes ☐ No
(If yes, please complete the Employer Account Registration Form on pg. 9)

Broker Signature ____________________

Date ____________________

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IMPLEMENTATION WORKSHEET
COBRA

COBRA INFORMATION

Which plans are eligible for COBRA?

☐ Medical - # of Plans:_____ ☐ Dental - # of Plans:_____ ☐ Vision - # of Plans:_____ ☐ RX Standalone - # of Plans:_____

☐ FSA ☐ HRA ☐ EAP* ☐ Other:_______________

**Not eligible if this is a referral service only*

Current COBRA Administration:

☐ Self ☐ Third Party - **Name of current administrator**: _______________

Number of Enrolled Qualified Beneficiaries: _______________ Number of Pending Qualified Beneficiaries: _______________

Are there any pending COBRA appeals? ☐ Yes ☐ No

If yes, please explain: _______________

Are you subject to State Continuation? ☐ Yes ☐ No

If yes, which state: _______________

Would you like to send coupons or premium notices? ☐ Coupons *(Recommended)* ☐ Premium Notices

Allow to send Spanish notices: ☐ Yes ☐ No

Benefits Setup

Group Effective Date with Surency: Date: _______________

When do your benefit plans renew? Date: _______________

When is your next scheduled open enrollment? Date: _______________

REMITTANCE - APPLIES TO ALL PLANS

Remit Premiums back to: ☐ Carrier (remitted via check) ☐ Client

For Client only: ☐ *Remit via Check* ☐ *Remit via ACH (complete form on pg. 11)*

Remittance Frequency: ☐ Weekly ☐ Monthly (5th of each month) ☐ Mid-Month (15th of each month)

Please note: You cannot change remittance options mid-year.

The Employer or Broker agrees to contact each insurance carrier to authorize Surency Cobra as their Third Party Administrator (TPA), prior to the effective date. This authorization grants Surency Cobra the ability to represent the account in making eligibility updates which involves the use and disclosure of Protected Health Information (PHI), and premium remittance, if selected.

Broker Signature: _______________ Date: _______________

Company Representative Signature: _______________ Date: _______________

IMPLEMENTATION WORKSHEET
COBRA

MEDICAL PLANS

General Plan Information	Medical Plan 1	Medical Plan 2	Medical Plan 3	Medical Plan 4
Plan Name				
Plan Type				
Rate Type *(traditional 4 tier or age-banded*)*				
Available for what divisions? *(mark all or specify which divisions)*				
Group #				
Plan #				
Is this plan self-funded** or fully insured?				
Is this plan bundled with any other plan?*** *(such as stand alone RX)*				
Plan Year Start Date				
Plan Year End Date				
Coverage End Date *(Event Date or End of Month)*				
Billing Start Date				
Conversion to Individual plan allowed? *(Yes or No)*				
For age banded rates, when do premiums change? *(Enrollment Date, Birthday or Renewal Date)*				
Carrier Information - Eligibility Contact Person				
Carrier Name				
Carrier Contact's Full Name				
Carrier Contact's Phone #				
Carrier Contact's Fax #				
Carrier Contact's Email				
Carrier Mailing Address				

Note: You are required to submit your Summary Plan Descriptions with plan setup. **If age-banded was chosen, please attach a breakdown of rates.*
***If self-funded was chosen, funds can only be remitted to the client.* ****If bundled with RX, please fill out PBM Carrier Information/Rates on pg. 4.*

MEDICAL MONTHLY RATES *(Note: please DO NOT add the 2% COBRA Premium to your rates)*

Coverage Levels	RATES: PLEASE COMPLETE THE APPLICABLE COVERAGE LEVELS LISTED. Example: If you only offer EE and Family coverages, don't answer the options for EE + Spouse and EE + Child(ren) .				
	Example	**Medical 1**	**Medical 2**	**Medical 3**	**Medical 4**
EE	$357.00				
EE + Spouse	$510.00				
EE + Child(ren)	$484.50				
Family	$663.00				

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IMPLEMENTATION WORKSHEET
COBRA

PHARMACY BENEFIT MANAGEMENT (PBM)

Carrier Information - Eligibility Contact Person	
Carrier Name	
Carrier Contact's Full Name	
Carrier Contact's Phone #	
Carrier Contact's Fax #	
Carrier Contact's Email	
Carrier Mailing Address	

PBM MONTHLY RATES *(Note: please DO NOT add the 2% COBRA Premium to your rates)*

Coverage Levels	RATES: PLEASE COMPLETE THE APPLICABLE COVERAGE LEVELS LISTED. Example: If you only offer EE and Family coverages, don't answer the options for EE + Spouse and EE + Child(ren) .				
	Example	**PBM 1**	**PBM 2**	**PBM 3**	**PBM 4**
EE	$357.00				
EE + Spouse	$510.00				
EE + Child(ren)	$484.50				
Family	$663.00				

DENTAL PLANS

General Plan Information	Dental Plan 1	Dental Plan 2	Dental Plan 3	Dental Plan 4
Plan Name				
Plan Type				
Rate Type *(traditional 4 tier or age-banded*)*				
Available for what divisions? *(mark all or specify which divisions)*				
Group #				
Plan #				
Is this plan self-funded** or fully insured?				
Plan Year Start Date				
Plan Year End Date				
Coverage End Date *(Event Date or End of Month)*				
Billing Start Date				
Conversion to Individual plan allowed? *(Yes or No)*				
For age banded rates, when do premiums change? *(Enrollment Date, Birthday or Renewal Date)*				

Carrier Information - Eligibility Contact Person	
Carrier Name	
Carrier Contact's Full Name	
Carrier Contact's Phone #	
Carrier Contact's Fax #	
Carrier Contact's Email	
Carrier Mailing Address	

Note: You are required to submit your Summary Plan Descriptions with plan setup.
**If age-banded was chosen, please attach a breakdown of rates.*
***If self-funded was chosen, funds can only be remitted to the client.*

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IMPLEMENTATION WORKSHEET
COBRA

DENTAL MONTHLY RATES *(Note: please DO NOT add the 2% COBRA Premium to your rates)*

Coverage Levels	RATES: PLEASE COMPLETE THE APPLICABLE COVERAGE LEVELS LISTED. Example: If you only offer EE and Family coverages, don't answer the options for EE + Spouse and EE + Child(ren) .				
	Example	**Dental 1**	**Dental 2**	**Dental 3**	**Dental 4**
EE	$357.00				
EE + Spouse	$510.00				
EE + Child(ren)	$484.50				
Family	$663.00				

VISION PLANS

General Plan Information	Vision Plan 1	Vision Plan 2	Vision Plan 3	Vision Plan 4
Plan Name				
Plan Type				
Rate Type *(traditional 4 tier or age-banded*)*				
Available for what divisions? *(mark all or specify which divisions)*				
Group #				
Plan #				
Is this plan self-funded**or fully insured?				
Plan Year Start Date				
Plan Year End Date				
Coverage End Date *(Event Date or End of Month)*				
Billing Start Date				
Conversion to Individual plan allowed? *(Yes or No)*				
For age banded rates, when do premiums change? *(Enrollment Date, Birthday or Renewal Date)*				
Carrier Information - Eligibility Contact Person				
Carrier Name				
Carrier Contact's Full Name				
Carrier Contact's Phone #				
Carrier Contact's Fax #				
Carrier Contact's Email				
Carrier Mailing Address				

Note: You are required to submit your Summary Plan Descriptions with plan setup.
**If age-banded was chosen, please attach a breakdown of rates.*
***If self-funded was chosen, funds can only be remitted to the client.*

VISION MONTHLY RATES *(Note: please DO NOT add the 2% COBRA Premium to your rates)*

Coverage Levels	RATES: PLEASE COMPLETE THE APPLICABLE COVERAGE LEVELS LISTED. Example: If you only offer EE and Family coverages, don't answer the options for EE + Spouse and EE + Child(ren) .				
	Example	**Vision 1**	**Vision 2**	**Vision 3**	**Vision 4**
EE	$357.00				
EE + Spouse	$510.00				
EE + Child(ren)	$484.50				
Family	$663.00				

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IMPLEMENTATION WORKSHEET
COBRA

FLEXIBLE SPENDING ACCOUNT (FSA)/HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

General Plan Information	FSA/HRA Plan 1	FSA/HRA Plan 2	FSA/HRA Plan 3	FSA/HRA Plan 4
Plan Name				
Plan #				
Carryover, Grace Period*, or N/A				
Plan Year Start Date				
Plan Year End Date				
Coverage End Date *(Event Date or End of Month)*				
Billing Start Date				
FSA Renewal Month				
Administrator Information - Eligibility Contact Person				
Administrator Name				
Administrator Contact's Full Name				
Administrator Contact's Phone #				
Administrator Contact's Fax #				
Administrator Contact's Email				
Administrator Mailing Address				

Note: You are required to submit your Summary Plan Descriptions with plan setup.
**Grace Period is not COBRA eligible.*

OTHER PLAN OFFERINGS

General Plan Information	Other Plan 1	Other Plan 2	Other Plan 3	Other Plan 4
Plan Name				
Plan Type				
Rate Type *(traditional 4 tier or age-banded*)*				
Available for what divisions? *(mark all or specify which divisions)*				
Group #				
Plan #				
Is this plan self-funded** or fully insured?				
Plan Year Start Date				
Plan Year End Date				
Coverage End Date *(Event Date or End of Month)*				
Billing Start Date				
Conversion to Individual plan allowed? *(Yes or No)*				
For age banded rates, when do premiums change? *(Enrollment Date, Birthday or Renewal Date)*				
Carrier Information - Eligibility Contact Person				
Carrier Name				
Carrier Contact's Full Name				
Carrier Contact's Phone #				
Carrier Contact's Fax #				
Carrier Contact's Email				
Carrier Mailing Address				

Note: You are required to submit your Summary Plan Descriptions with plan setup.
**If age-banded was chosen, please attach a breakdown of rates.*
***If self-funded was chosen, funds can only be remitted to the client.*

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IMPLEMENTATION WORKSHEET
COBRA

OTHER PLAN MONTHLY RATES *(Note: please DO NOT add the 2% COBRA Premium to your rates)*

Coverage Levels	RATES: PLEASE COMPLETE THE APPLICABLE COVERAGE LEVELS LISTED. Example: If you only offer EE and Family coverages, don't answer the options for EE + Spouse and EE + Child(ren) .				
	Example	**Other Plan 1**	**Other Plan 2**	**Other Plan 3**	**Other Plan 4**
EE	$357.00				
EE + Spouse	$510.00				
EE + Child(ren)	$484.50				
Family	$663.00				

SIGNATURE

I certify that all information provided in this form is accurate and complete to the best of my knowledge and belief, and that Surency may rely on the information presented herein.

Signature: ______________________________ Date: ______________

Want to sign up for Direct Billing? Continue on to the Benefit Manager forms attached. If not, return completed form back to Surency.

FOR INTERNAL USE ONLY

1. Sales Executive: ______________________

2. Account Executive: ______________________

Effective Date: ______________________

Group Number: ______________________
(5 digit unique employer identifier)

Group Billing: ☐ Manual ☐ ACH

Set Up Fee: ______________________

Renewal Fee: ______________________

Monthly Admin Fee: ______________________

Rate Guarantee: ______________________

Minimum PPPM Fee: ______________________

Underwriting: ______________________

Date: ______________________

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EMPLOYER ACCOUNT FOR BENEFITS MANAGERS
COBRA

This document will help you get access to your Surency COBRA Employer Account and COBRA-Bills Account.

EMPLOYER ACCOUNT REGISTRATION

After online enrollment has been set up and confirmed, you will be able to access your Surency COBRA Employer Account. To become an authorized user of our website, Surency COBRA will send you a unique registration code to set up your account. Visit cobra.surency.com and click NEW USER link and follow the registration process.
Please note: You will be asked to enter your company's tax identification (EIN) number upon initial registration.

Your Surency COBRA Employer Account will give you access to online eligibility for qualified beneficiaries and new hires, ad hoc reporting functions and view consumer/group level notices.

It is recommended that no more than three (3) individuals be authorized to access the data. If new/additional access is needed, please resubmit this form.

If you have any problems logging in, please contact the Sales department at 800-264-9462 or via email at marketing@surency.com.

ONLINE BILLING (COBRA-BILLS ACCOUNT)

You may choose to receive your monthly billing statement electronically through our website at Surency.com. If you choose this option, you will receive a monthly email reminder when the bill is posted to our website. You can view and download the billing by logging in to your *COBRA-Bills Account*.

WHERE TO SEND YOUR COMPLETED EMPLOYER ACCOUNT REGISTRATION FORMS

If you would like to have access to your COBRA Employer Account and COBRA-Bills Accounts as explained above, fill out the attached Employer Account Registration Forms and either fax back to Surency at *316-272-4842* or email to: *cobra@surency.com.*

If new/additional access is needed, please resubmit this form.

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EMPLOYER ACCOUNT REGISTRATION FORM

(Please retain a copy of this completed form for your records.)

COBRA

Complete this form to have access to your *Surency COBRA Employer Account.* It is recommended that no more than three (3) individuals be authorized to access the data. If new/additional access is needed, please resubmit this form.

Group Name: ______________________ Group Number: ______________________

ADMINISTRATIVE USERS:

Please indicate all contacts.

Date	Contact Name/Title	Email Address	Phone Number

Name: ______________________ ☐ Broker ☐ Employer

EIN: ______________________ Phone Number: ______________________

Email Address: ______________________ *(this is the email address that will be used to log in to your Employer Account)*

User Signature: ______________________ Date: ______________

Employer authorization for Broker/Agency online access: (if applicable)

Print Name: ______________________ Date: ______________

Employer Signature: ______________________

Once access has been activated, an email will be sent to inform each contact of their Username and Password and instructions on how to log in to their Surency COBRA Employer Account. Following the first successful log in, users will be prompted to change their password and choose a security question.

Disclaimer: It is the employer's responsibility to notify Surency immediately in writing, via fax 316-462-3329, or email marketing@surency.com, when an employee's access to online services should be terminated. Surency shall not be held liable for any unauthorized access to the group's online services, or online changes made to the group's benefits and eligibility unless the employer has submitted written notification to Surency prior to any unauthorized access.

INTERNAL USE ONLY:

Set up by: ______________________ Date: ______________

Return completed form to Surency at email: cobra@surency.com - fax: 316-272-4842

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BILLS ACCOUNT REGISTRATION FORM

(Please retain a copy of this completed form for your records.)

COBRA

Complete this form to access your billings online at Surency.com. *Fill out one form per person.*

GROUP NAME	GROUP NUMBER *(Use all 18 digits of group number; each group and/or subgroup has an individual group number and must be listed)*
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

☐ I am replacing the main billing account ☐ I am an additional user

CREATE A TEMPORARY PASSWORD*:

PASSWORD REQUIREMENTS:

- *Minimum of eight (8) and a maximum of 15 characters*
- *at least one (1) uppercase letter*
- *at least one (1) lowercase letter*
- *at least one (1) number*

**Following the first successful log in, users will be prompted to change their password and to choose a security question.*

Name: ______________________ Phone Number: ______________________

Email Address: ______________________ *(this is the email address that will be used to log in to your Employer Account)*

User Signature: ______________________ Date: ______________________

Disclaimer: It is the employer's responsibility to notify Surency immediately in writing, via fax 316-462-3329 or email marketing@surency.com, when an employee's access to online services should be terminated. Surency shall not be held liable for any unauthorized access to the group's online services, or online changes made to the group's benefits and eligibility unless the employer has submitted written notification to Surency prior to any unauthorized access.

Return completed form to Surency at email: cobra@surency.com - fax: 316-272-4842

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CLIENT REMITTANCE FORM
COBRA

Company Name: ______________________ Contact Name: ______________________

Title: ______________________ Email Address: ______________________

Phone: ______________________ Fax: ______________________

CLIENT REMITTANCE

For remitting premiums from Qualified Beneficiary and Direct Bill back to client.

BANK ACCOUNT INFORMATION

Requesting Reimbursement from? ☐ Checking ☐ Savings

____
Name of Financial Institution

______________________ ______________________ ______________________ ______________________
Mailing Address City State Zip Code

____
Transit/ABA Routing Number

____
Account Number *(A voided check or account verification letter from the financial institution must be attached for this account.)*

By signing, I represent to Surency that I am an authorized representative for the company named above (“Company”). Acting as the Company’s Receiver, I authorize Surency to initiate debit entries, credit entries, and adjustments to any credit entries made in error to the bank account stated above in accordance with the National Automated Clearing House Association (“NACHA”) Operating Rules. In addition, this authorization will be deemed to constitute a Standing Authorization under NACHA Operating Rules. This authorization will be deemed effective on the date Surency receives this form and continue until an authorized representative of the Company notifies Surency of its intent to terminate this authorization.

Employer’s Signature: ______________________ Date: ______________________

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