DIRECT BILLING RENEWAL WORKSHEET

Surency COBRA

Company Information

Company Name _____ Tax ID Number (EIN) _____

Number of Eligible Employees: _____

Company Contacts

Day-to-Day Contact: *If your day-to-day contact information has changed, please update here.*

Name _____ Title _____

Email _____

Phone Number _____

Billing Contact: *If your billing contact is different from the above or has changed, please update here.*

Billing Contact _____ Email _____

Address _____

City, State, ZIP _____

Direct Billing Information

Which plans are eligible for Direct Billing?

☐ 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.**

Benefits Set Up:

When is your scheduled open enrollment? Start Date: _____ End Date: _____

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Applies To All Plans

Remittance: *Remittance will continue using the current method, unless you elect a change here.*

Please change remit Premiums back to: ☐ Carrier ☐ Client **(Please note: This will apply to all selected plans.)**

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

Please note: You cannot change remittance options mid year.

Documentation: Benefit Plan & Rate Information

Please provide benefit plan and rate information via a separate document. The following information must be included for each plan that is eligible for Direct Billing.

- **Name of Carrier**
- **Plan Name**
- **Rate Band for Each Coverage Level (Please do NOT include the 2% premium in rate bands.)**

Please attach documentation in Excel, Word or PDF format only.

*If attached documentation is **not** included, please contact us for an expanded Renewal Worksheet that you may use to fill out that information.*

Signature

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

Signature: _____ Date: _____

For Internal Use Only

Renewal Date: _____ Group Number: _____
(5 digit unique employer identifier)

Renewal Fee: _____ Monthly Admin Fee: _____

Rate Guarantee: _____ Minimum PPPM Fee: _____

Underwriting: _____ Date: _____

Return completed form back to Surency at email: marketing@surency.com - fax: 316-462-3329
or mail: P.O. Box 789706, Wichita, KS 67278-9706, Attn: Sales Dept.

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