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 continue on to Page 3 to complete this worksheet.

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: _____

DIRECT BILLING RENEWAL WORKSHEET

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MEDICAL PLANS *(List all current plans and any plans being added for the upcoming year.)*

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? (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: It is 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 (Please note: *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				

DIRECT BILLING RENEWAL WORKSHEET

Surency COBRA

DENTAL PLANS *(List all current plans and any plans being added for the upcoming year.)*

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? (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: It is 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.**

DENTAL MONTHLY RATES (Please note: *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				

DIRECT BILLING RENEWAL WORKSHEET

Surency COBRA

VISION PLANS *(List all current plans and any plans being added for the upcoming year.)*

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? (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: It is 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 (Please note: *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				

DIRECT BILLING RENEWAL WORKSHEET

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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 (Please note: *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				

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

DIRECT BILLING RENEWAL WORKSHEET

Surency COBRA

OTHER PLAN OFFERINGS *(List all current plans and any plans being added for the upcoming year.)*

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? (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: It is 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.**

OTHER PLAN MONTHLY RATES (Please note: *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: _____

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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