COBRA PLAN IMPLEMENTATION WORKSHEET

Surency 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 Number _____ Employer Portal Access? ☐ Yes ☐ No
(If yes, please complete Online Registration Form attached)

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

Billing Contact _____ Email _____

Address _____

City, State, ZIP _____

COBRA PLAN IMPLEMENTATION WORKSHEET

Surency 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

BENEFITS SETUP

Group Effective Date with Surency: Date: _____

When do your benefit plans renew? Date: _____

When is your next scheduled open enrollment? Date: _____

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: _____

COBRA PLAN IMPLEMENTATION WORKSHEET

Surency COBRA

APPLIES TO ALL PLANS

REMITTANCE

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

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? (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 (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				

COBRA PLAN IMPLEMENTATION WORKSHEET

Surency 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? (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.**

COBRA PLAN IMPLEMENTATION WORKSHEET

Surency 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? (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.**

COBRA PLAN IMPLEMENTATION WORKSHEET

Surency COBRA

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				

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.**

COBRA PLAN IMPLEMENTATION WORKSHEET

Surency COBRA

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? (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 (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 pg. 8. If not, return completed form back to Surency.

DIRECT BILLING

Surency COBRA

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 a referral only service**

Current Direct Billing Administration:

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

What billing types will be utilized? (select all that apply)

☐ Retiree ☐ Premium Pay ☐ LTD Premium ☐ FMLA ☐ Leave of Absence ☐ Loan Repayment

Number of Enrolled Members? _____

Do you allow the members to elect? ☐ Yes ☐ No

If yes, please explain: _____

Are there any pending direct bill appeals? ☐ Yes ☐ No

If yes, please explain: _____

Do you allow grace periods for premium payments? ☐ Yes ☐ No

If yes, please explain: _____

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

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: cobra@surency.com - fax: 316-272-4842
or mail: P.O. Box 789706, Wichita, KS 67278-9706
800-264-9462 • Surency.com

Employer Account for Benefit Managers

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

Surency COBRA 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 regristration code to set up your account. Visit cobra.surency.com and click on 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.

Surency COBRA - Employer Account Registration Form

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

Surency COBRA - Employer Account

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.

Internal Use Only:

Set up by: _____ 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 back to Surency at email: cobra@surency.com or fax: 316-272-4842

800-264-9462 • Surency.com

Surency COBRA-Bills Account Registration Form

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

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

Online Billing (Surency COBRA-Bills Employer Account)

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 back to Surency at email: cobra@surency.com or fax: 316-272-4842

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