

# COBRA RENEWAL WORKSHEET



## 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 \_\_\_\_\_

## 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.**

## 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 COBRA.

- **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: _____

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

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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 Information				
Carrier Name				
Eligibility Contact				
Eligibility Phone #				
Eligibility Fax #				
Eligibility Email				
Eligibility 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				

# COBRA RENEWAL WORKSHEET



## 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)				
<b>Carrier Information - Eligibility Contact Information</b>				
Carrier Name				
Eligibility Contact				
Eligibility Phone #				
Eligibility Fax #				
Eligibility Email				
Eligibility 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				

# COBRA RENEWAL WORKSHEET



## 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)				
<b>Carrier Information - Eligibility Contact Information</b>				
Carrier Name				
Eligibility Contact				
Eligibility Phone #				
Eligibility Fax #				
Eligibility Email				
Eligibility 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				

# COBRA RENEWAL WORKSHEET



## PHARMACY BENEFIT MANAGEMENT (PBM)

### Carrier Information - Eligibility Contact Information

Carrier Name	
Eligibility Contact	
Eligibility Phone #	
Eligibility Fax #	
Eligibility Email	
Eligibility 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 Information				
Administrator Name				
Eligibility Contact				
Eligibility Phone #				
Eligibility Fax #				
Eligibility Email				
Eligibility Mailing Address				

**Note: It is required to submit your Summary Plan Descriptions with plan setup.**

**\*Grace Period is not COBRA eligible.**

# COBRA RENEWAL WORKSHEET



## 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 Information	
Carrier Name	
Eligibility Contact	
Eligibility Phone #	
Eligibility Fax #	
Eligibility Email	
Eligibility 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: \_\_\_\_\_

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