



# American Benefit Services

## COBRA ADMINISTRATION QUESTIONNAIRE

Company Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Accounting Contact Name (if diff.): \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

Email Address: \_\_\_\_\_

COBRA administration by ABS will be effective (date): \_\_\_\_\_

### Initial COBRA Notification:

ABS will send initial COBRA notices to all new hires.

Have initial notices been sent to your existing employees? Yes \_\_\_ No \_\_\_

- If no, would you like ABS to send a one-time mailing to your existing employees for a fee of \$2.75 ea. ? \_\_\_ Yes \_\_\_ No, the Employer will send these

Social Security Disability (29 mos.): IRS will allow you to charge 150% for an 11 month extension.

Do you wish to charge allowable 150% for 11-month extension? Yes \_\_\_ No \_\_\_

Do you have an open enrollment period? \_\_\_ Yes \_\_\_ No - If yes, when? \_\_\_\_\_

Eligibility Waiting Period after hire date: \_\_\_\_\_ days, \_\_\_\_\_ Months

### Entry Date:

\_\_\_ Date eligibility requirements are met

\_\_\_ First day of the month following date eligibility requirements are met

\_\_\_ Other: \_\_\_\_\_

Coverage Terms: \_\_\_ Last day worked \_\_\_ end of month after last day worked \_\_\_ Other: \_\_\_\_\_

Health Plan Year: Begins: \_\_\_\_\_ Ends \_\_\_\_\_

**Administrators/Carriers:**

**Medical:**

\_\_\_\_\_

Company

\_\_\_\_\_

Contact Name

\_\_\_\_\_

Phone #

\_\_\_\_\_

Total # of covered employees

**Dental:**

\_\_\_\_\_

Company

\_\_\_\_\_

Contact Name

\_\_\_\_\_

Phone #

\_\_\_\_\_

Total # of covered employees

**Other:**

\_\_\_\_\_

Coverage

\_\_\_\_\_

Company

\_\_\_\_\_

Contact Name

\_\_\_\_\_

Phone #

\_\_\_\_\_

Total # of covered employees

**Are there any existing COBRA Participants? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**If yes, please provide ABS with the following information:**

- SS# of Principal Qualified Beneficiary (employee)
- Name and Address (including separate address for dependent(s), if applicable)
- Date of Birth
- Dependent(s) Names
- Coverage (single medical, family dental, ect)
- Date of Qualifying Event
- Event?
- Through what date have COBRA premiums been paid?
- Are there currently any outstanding issues with the participant or dependents?
- Agents Name

**COBRA Rates:**

**Please provide your current insurance rates to ABS.**

**Be sure to include:**

**Packaging information, such as: medical and dental combined or offered separately**

**Levels of coverage, such as: employee, employee/spouse, or employee/children, family**

**Do the rates provided include the 2% COBRA Administration Fee? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**Agent:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Employer Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_