

**FLEXIBLE BENEFIT ADMINISTRATORS, INC. - COBRA DIVISION**

**CLIENT ENROLLMENT FORM**

Client Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

**CONTACTS: Who should we contact at your company if we have questions?**

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

Title: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Fax: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**QUESTIONS:**

1. When does an employee's benefit plan terminate under your insurance policies? Does their coverage extend until the end of the month or does it terminate on their COBRA qualifying event date? \_\_\_\_\_
2. Are you currently providing Initial COBRA Rights Notices to employees at the time an employee enrolls in your benefit plan? (This is required by the IRS regulations) \_\_\_\_\_  
If not, would you like FBA to provide a Global Mailing (Optional Service), notifying all currently enrolled employees of their COBRA rights in order to bring your company to COBRA compliancy? \_\_\_\_\_  
If your company has been providing Initial COBRA Rights Notices, FBA can begin providing the notices for you to all new enrollees. \_\_\_\_\_
3. Approximately how many active employees are currently enrolled in your medical, dental, and vision plans? \_\_\_\_\_
4. Do you currently have anyone enrolled with COBRA? If so, how many? \_\_\_\_\_ or in their 60-day election period? If so, how many? \_\_\_\_\_ or who recently experienced a COBRA qualifying event and need notified with a COBRA packet? \_\_\_\_\_
5. Who are your current insurance carriers for Medical \_\_\_\_\_  
Dental \_\_\_\_\_ Vision \_\_\_\_\_
6. Do you presently have COBRA sub group numbers set up with your insurance carriers? \_\_\_\_\_
7. When is the Renewal Date for your benefit plans? Medical \_\_\_\_\_ Dental \_\_\_\_\_ Vision \_\_\_\_\_
8. Are your benefit plans fully-insured or self-insured? \_\_\_\_\_
9. If applicable, your employees can continue their Healthcare Reimbursement Account through COBRA if they have a positive balance at the time of termination. Do you offer a Flexible Spending Account (FSA) or Healthcare Reimbursement Arrangement (HRA) to your employees? \_\_\_\_\_
10. Does your group health plan contain conversion rights (The right to convert group health plan coverage to an individual insurance policy without providing proof of insurability)? \_\_\_\_\_ If so, would you like FBA to provide notices to COBRA participants explaining their conversion rights? (Optional Service) \_\_\_\_\_

Please list all medical, dental and vision plans you currently offer to your employees. We will need to know the exact rate that is charged to you by the insurance carrier. Please DO NOT include the 2% COBRA fee when you list the rates.

**BENEFIT PLANS & RATES:**

Carrier Name: \_\_\_\_\_

Benefit Plan Name: \_\_\_\_\_

Please list the monthly rates charged for coverage:

Member Only \$ \_\_\_\_\_

Member & Spouse \$ \_\_\_\_\_

Member & One Child \$ \_\_\_\_\_

Member & Two or More Children \$ \_\_\_\_\_

Member & Family \$ \_\_\_\_\_

Insurance Carrier  
Contact Person: \_\_\_\_\_

Contact's Telephone #: \_\_\_\_\_

Contact's Fax #: \_\_\_\_\_

Contact's E-Mail Address: \_\_\_\_\_

Contact's Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Active Employee Group #: \_\_\_\_\_

COBRA Sub Group #: \_\_\_\_\_

**BENEFIT PLANS & RATES:**

Carrier Name: \_\_\_\_\_

Benefit Plan Name: \_\_\_\_\_

Please list the monthly rates charged for coverage:

Member Only \$ \_\_\_\_\_

Member & Spouse \$ \_\_\_\_\_

Member & One Child \$ \_\_\_\_\_

Member & Two or More Children \$ \_\_\_\_\_

Member & Family \$ \_\_\_\_\_

Insurance Carrier  
Contact Person: \_\_\_\_\_

Contact's Telephone #: \_\_\_\_\_

Contact's Fax #: \_\_\_\_\_

Contact's E-Mail Address: \_\_\_\_\_

Contact's Address: \_\_\_\_\_

\_\_\_\_\_

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Active Employee Group #: \_\_\_\_\_

COBRA Sub Group #: \_\_\_\_\_

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**Member & One Child \$** \_\_\_\_\_

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Contact Person:** \_\_\_\_\_

**Contact's Telephone #:** \_\_\_\_\_

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**Contact's E-Mail Address:** \_\_\_\_\_

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**COBRA Sub Group #:** \_\_\_\_\_

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Contact Person:** \_\_\_\_\_

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**Contact's Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Active Employee Group #:** \_\_\_\_\_

**COBRA Sub Group #:** \_\_\_\_\_

**\*\*Please also provide FBA with copies of the documents from the insurance carriers that list the effective date, assigned group number and the monthly rate tiers, copies of Summary of Benefits and an enrollment application for each carrier to be placed on file.**