BRS COBRA ADMINISTRATION SERVICES

NEW GROUP APPLICATION

Please indicate by checking COBRA ___ or State Continuation ___

Employer Information:

Company Name **EIN#**

Street **City** **State** **Zip+4**

Mailing Address (if different from above)

Administrative Contact **Title**

E-mail address

Telephone **Fax**

Executive Contact **Title**

E-mail address

Telephone **Fax**

Effective Date of Service: _______________

Approximate Number of Benefited Employees: _____

Number of Current COBRA Participants: Pending: _____ Enrolled: _____

Have your existing benefited employees been provided with General Rights Notices? (Y/N) _____

Signature of Administrator: _____ Date: _____

Please complete a Group Benefits COBRA Set-up form for each COBRA eligible plan.
(Attachment A of application)

BUSINESS RESOURCE SERVICES

Group Benefits COBRA Set-up *Attachment A of application*

Make additional copies of this form as needed and attach a copy of the most recent billing from this carrier

Group Name: _____

Carrier/TPA Name _____

Type of Coverage _____ (Medical, Dental, Vision, FSA, HRA, EAP, etc.)

Type of Plan _____ (HMO, PPO, POS, DMO, DPO, etc.) Internal Plan Code _____

Plan Policy # _____ Effective Date _______________

Is this plan available only to a specific company division or employee class? ____ Yes _____ No

If YES, which division(s) or class(es): _____

Coverage Termination: ____ Event Date _____ End of Month ____ Other: _____

Does the plan offer conversion? _____ YES _____ NO

Is this plan bundled with any other plan (includes stand-alone Rx)? If yes, which plan: _____

Insurance Cust Svc _____ Telephone _____ Fax _____

Enrollment Contact _____ Telephone _____ Fax _____

Enrollment Address _____ City _____ State & Zip _____

Do you have online eligibility access ____ YES ___ NO If yes, provide User ID & password _____

Number of days Carrier will accept coverage termination notices: _____ 0 Days ____ 30 Days ____ 60 Days

Please attach any enrollment/change forms for this carrier.

Insurance Rate Effective Date _______________ Insurance Rate Renewal Date _______________

COVERAGE	**MONTHLY PREMIUM AS BILLED BY CARRIER**
Employee Only	$_____
Employee + Spouse	$_____
Employee + Child	$_____
Employee + Children	$_____
Family	$_____

BRS BUSINESS RESOURCE SERVICES