



COBRA

OUTSOURCING COMPANY

National Administrators of COBRA

GENERAL INFORMATION

Please complete the following 'New Client Setup Checklist' form. This form is Schedule B to the Client Service Agreement. The information provided on this form will be used to build your company into our COBRA administration system. It is important to verify the accuracy of all information.

To ensure we are able to deliver our highest level of customer service, please review the following items.

- 1) Confirm that each carrier places your COBRA participants on the active employee group list billing provided to you by each carrier. The carrier(s) should not direct bill the COBRA participants.
- 2) Confirm that each carrier is aware that COBRA Outsourcing Company will be responsible for reinstating and terminating COBRA continuation coverage under your plan.
- 3) Submit a copy of your most recent medical billing statement or billing summary indicating the current number of active employees.
- 4) Be sure to include all benefit plans we are to administer COBRA for on the Carrier/Premium information page. This includes any stand-alone pharmacy benefit plans with a separate administrator from your medical carrier.



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COBRA NEW CLIENT SET-UP CHECKLIST *Schedule B to Client Service Agreement*

Billing Method:

- ACH
- Annual
- Semi-Annual

Office Use Only

Client Code: _____

Broker Code: _____

CSS Rec'd: ____/____/____

Employer Information:

Company Name

EIN#

Street

City

State

Zip+4

Mailing Address (if different from above)

Administrative Contact

Title

Executive Contact

Title

E-mail address

E-mail address

() -
Telephone

() -
Fax

() -
Telephone

() -
Fax

Divisions (if any): _____

Will the divisions need to be tracked as separate entities for reporting requirements? YES NO

Eff. date of COBRA Admin Service: ____________ (Completed setup forms must be rec'd 30days prior to effective date.)

of Employees on Medical Billing: _____ # of Current COBRA Participants: Pending: _____ Enrolled: _____

Do you now or expect to in the future offer COBRA premium severance packages to qualified beneficiaries? YES NO
If yes, please provide details regarding COBRA related severance packages.

Do you have Internet access? YES NO

Our Broker/TPA/Association will handle the event notification process on our behalf: YES NO

This authorizes our Broker/TPA/Association to have login privileges for the COBRA Outsourcing Company website.

COBRA notification data will be submitted via file transfer: YES (Refer to Schedule A for pricing details.) NO

Broker/TPA/Association Information:

Firm Name

Producer's Name

EIN# or Producer's SSN

Street

City

State

Zip+4

() -
Telephone

() -
Fax

E-Mail

Account Manager

() -
Telephone

E-Mail

**Complete the following for each COBRA eligible plan.
Make additional copies of the form as needed.**

Carrier/TPA Name _____

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

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

Waiting Period _____ Days Is this the same for all employees? YES NO If no, explain different waiting periods. _____

Is this plan available only to a specific company division or employee class? YES NO

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

Plan Policy # _____ Effective Date ____________ Fully-Insured Plan Self-Insured Plan

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: _____

Cust. Svc. Contact _____ Telephone () - Fax () -

Enrollment Contact _____ Telephone () - Fax () -

Enrollment Address _____ City _____ State _____ Zip _____

Will COCO have online eligibility access? YES NO If yes, provide login code and instructions.

Does the Carrier/TPA require COBRA premium 'paid-through' reports? YES NO

If yes, what is the frequency? Weekly Monthly

Can COCO send EDI files for COBRA elections/terminations/changes? YES NO If yes, submit file specifications and transmission instructions.

Does Carrier require specific COBRA election forms? YES NO If yes, provide copy of the form in .pdf format. _____

Plan Rates: Composite Age/Gender Table

Rate Effective Date ____________ Rate Renewal Date ____________

If the plan rates are composite, complete the following.

STANDARD COVERAGE	MONTHLY PREMIUM (WITHOUT 2%)	NON-STANDARD COVERAGE	MONTHLY PREMIUM (WITHOUT 2%)
Employee Only	\$ _____	_____	\$ _____
Employee + Spouse	\$ _____	_____	\$ _____
Employee + Child	\$ _____	_____	\$ _____
Employee + Children	\$ _____	_____	\$ _____
Family	\$ _____	_____	\$ _____

If the plan rates are age/gender based, attach a copy of the age/gender rate table.