

**BRS COBRA / VIPER SERVICES**  
**NEW GROUP APPLICATION**

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**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

Effective Date of Service: \_\_\_\_\\_\_\_\_\\_\_\_\_

Approximate Number of Benefited Employees: \_\_\_\_\_

Number of Current COBRA Participants: Pending: \_\_\_\_\_ Enrolled: \_\_\_\_\_

New Hire Waiting Period: \_\_\_\_\_ Is the waiting period the same for all employees/plans?  YES  NO

If NO, please list employee classes and plans with their respective waiting periods.

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



**Group Benefits COBRA/VIPER Set-up**

*Attachment A of application*

***Make additional copies of this form as needed.***

Group Name: \_\_\_\_\_

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 \_\_\_\_\_

Plan Policy # \_\_\_\_\_ Effective Date \_\_\_\_\\_\_\_\_\\_\_\_\_  Fully-Insured Plan  Self-Insured Plan

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 enrollment/change form for this carrier.

Plan Rates:  Composite  Age/Gender Table

Rate Effective Date \_\_\_\_\\_\_\_\_\\_\_\_\_ Rate Renewal Date \_\_\_\_\\_\_\_\_\\_\_\_\_

**If the plan rates are composite, complete the following.**

**COVERAGE                      MONTHLY PREMIUM AS BILLED BY CARRIER**

Employee Only                      \$ \_\_\_\_\_

Employee + Spouse                      \$ \_\_\_\_\_

Employee + Child                      \$ \_\_\_\_\_

Employee + Children                      \$ \_\_\_\_\_

Family                      \$ \_\_\_\_\_

