COBRA Group Enrollment Form

Company Name ______________________ PH # ______________________

Mailing Address ______________________ FX # ______________________

City, ST, Zip ______________________ Email: ______________________

Person to contact Best method of contact: ❑ Email ❑ Fax ❑ Phone ❑ Mail

Medical Plan Provider ______________________ Renewal Date ______________

Billing Address ______________________ City/ST/Zip ______________

PH # ______________________

Rates**:	Emp Only	With Spouse	Family	With Child(ren)

Dental Plan Provider ______________________ Renewal Date ______________

Billing Address ______________________ City/ST/Zip ______________

PH # ______________________

Rates**:	Emp Only	With Spouse	Family	With Child(ren)

Vision Plan Provider ______________________ Renewal Date ______________

Billing Address ______________________ City/ST/Zip ______________

PH # ______________________

Rates**:	Emp Only	With Spouse	Family	With Child(ren)

***** If rates are age rated instead of tiered, you must provide a copy of your contract with the rates.***

Cafeteria Plan (section 125) ❑ Yes ❑ No

Health Reimbursement Plan ❑ Yes ❑ No

Other COBRA Qualifying Plan ❑ Yes ❑ No

Our current administrator is: ______________________

Current COBRA Participants- You MUST complete their information on the census

Name	Date of Termination	Involuntary?	Enrollment

We elect to have the following plan:

- ❑ Guaranteed plan at 75 cents per active employee
- ❑ $10 per Qualifying event letter, PBS to collect 2% from COBRA participant
- ❑ $10 per Qualifying Event letter, $6 per month per COBRA participant

❑ Yes ❑ No We wish to charge the COBRA participant a 2% administrative fee

❑ Yes ❑ No We wish to have PBS collect the COBRA premiums from participants

__________ Return premiums back to group

__________ Pay carriers directly

Other Requests:

____

____

____

____

____

____

____