## COBRA - Implementation Check List

Please complete the following forms and return to clientservices@asibenefits.com or fax to 559.475.5787:

- ASi Universal Employer Application
- Set-up Forms
    - Plan Rates
    - Notices (if applicable)
    - Total number of active employees enrolled on the qualified group benefits plan(s)

| Notes: |
| --- |
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**Administrative Solutions, Inc. (ASi)**
P. O. Box 5809 | Fresno, CA 93755
Ph. 559.256.1320 | Fax 559.475.5787
clientservices@asibenefits.com | www.asibenefits.com

# COBRA Set-up Form

**Company Name:** ____________________________________________________________

Date COBRA Administration to Become Effective: _____/_____/______

Insurance Type: ☐Medical ☐Dental ☐Vision ☐Section 125 FSA: Plan Administrator _____________________

☐Other: _______________ Plan Year____________________________

**Total number of active enrolled employees in a benefit plan:** _________

## COBRA ADMININSTRATION SERVICES:

### 1. COBRA Initial Notification –

COBRA compliance requires that all employees who are enrolled into a COBRA eligible benefits plan be notified of their COBRA rights upon enrollment.

**Employees –** Are there active employees currently enrolled with benefits or recent newly enrolled employees who need initial notification?

☐**Yes** ☐**No** →**If yes,** please submit information on the **"COBRA Initial Notification"** form.

**Future Enrollees –** ASi will provide an Initial COBRA Notification to all newly enrolled employees that are sent to ASi on the **"COBRA Initial Notification"** form. ASi is not responsible for notifications for new enrollees that are not sent to our office for processing. **Please be advised this is for new enrollees to a benefit plan, not new hires that may waive benefits.**

### 2. Current/Pending COBRA Participant –

ASi will provide each current COBRA participant a letter regarding the change in COBRA administrator. In order to send this letter we will need the information on the **"Current/Pending COBRA Participant"** form.

Are there any current/pending COBRA participants enrolled for COBRA?

☐**Yes** ☐**No** →**If yes,** please complete the enclosed **"Current/Pending COBRA Participant"** form and return it to our office for those who are currently enrolled as COBRA participants. If you have multiple COBRA participants you can send us a spreadsheet as long as it captures the information we need on the **"Current/Pending COBRA Participant"** form.

### 3. Qualifying Event Notification –

Are there employees who have had a qualifying event that need a COBRA Election Packet?

☐**Yes** ☐**No** →**If yes,** please complete the **"COBRA Notice of Qualifying Event"** form and return it to our office for processing.

### 4. For Administrative questions or issues, including COBRA appeals, whom should ASi contact?

☐**Broker** ☐**Client**

**Note: Please advise if the client would like ASi to work directly with the insurance carrier(s) on the COBRA enrollments and/or COBRA terminations. Otherwise, the standard interaction will be between ASi and the client.**

**Please be advised that ASi administers Federal COBRA only and <u>does not</u> provide any notification of California-COBRA for the extension of benefits if eligible.**

**Completed by:**____________________________________________ **Title:**____________________________________

# COBRA Plan Rates

**Company Name:** ______________________________ ***Attach Rate Table for Age Rated Plans**

**Group Carrier Rate and Plan Information:**

Carrier Name ______________________________ Plan Renewal Date _____/_____/_____
Plan Name ______________________________ Plan Effective Date _____/_____/_____

Type of Coverage ___________

Rates: Monthly Rate (without the 2%)

Employee Only _______ Composite Rate _________
Employee Plus One _______
Employee Plus Spouse _______
Employee Plus Child _______
Employee Plus Children _______
Family _______

**Group Carrier Rate and Plan Information:**

Carrier Name ______________________________ Plan Renewal Date _____/_____/_____
Plan Name ______________________________ Plan Effective Date _____/_____/_____

Type of Coverage ___________

Rates: Monthly Rate (without the 2%)

Employee Only _______ Composite Rate _________
Employee Plus One _______
Employee Plus Spouse _______
Employee Plus Child _______
Employee Plus Children _______
Family _______

**Group Carrier Rate and Plan Information:**

Carrier Name ______________________________ Plan Renewal Date _____/_____/_____
Plan Name ______________________________ Plan Effective Date _____/_____/_____

Type of Coverage ___________

Rates: Monthly Rate (without the 2%)

Employee Only _______ Composite Rate _________
Employee Plus One _______
Employee Plus Spouse _______
Employee Plus Child _______
Employee Plus Children _______
Family _______

**Please note: If you have Kaiser Permanente as one of your benefit plan carriers, please advise ASi if Kaiser is handling the enrollment, payments and billings. If Kaiser is going to handle, ASi is not responsible for the tracking or COBRA notifications that we are not made aware of.**

# COBRA Initial Notification

**IMPORTANT:** Please complete and return this form to ASI - our contact information is provided below:
This form is to be completed for actively working employees who are enrolled into COBRA eligible benefits plan(s).

**Employer Name:** ______________________________

**Name of Employee:** ______________________________

**Employee Date of Birth:** ______________________________

**Employee First Date of Coverage:** ______________________________

**Employee SSN #:** ______________________________

**Employee Mailing Address** ______________________________

______________________________

**Name of Spouse:** ______________________________ **Date of Birth:** ____________________

**Dependent:** ______________________________ **Date of Birth:** ____________________

**Dependent:** ______________________________ **Date of Birth:** ____________________

**Dependent:** ______________________________ **Date of Birth:** ____________________

**Dependent:** ______________________________ **Date of Birth:** ____________________

**Spouse / Dependent's Address if Different from Employee:**

______________________________

______________________________

______________________________ ____________________
**Signature of Employer or Employer Representative** **Date**

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Ph. 559.256.1320 / Toll Free 866.777.1320
Fax 559.475.5781 / cobradepartment@asibenefits.com

# Current/Pending COBRA Participant

**Instructions:** This form requires completion for those who are enrolled into COBRA at the time the group becomes effective with ASI and should be sent to our office. This form should also be completed and sent to our office for anyone previously notified of their COBRA rights and currently in their election window. Please see out contact information below.

**Employer Name:** ______________________________

**Name of Primary Beneficiary:** ______________________________ **Beneficiary's Social Security #:** ______________________________

**First Date of Coverage:** ______________________________ (Active Group Coverage) **Beneficiary's Mailing Address:** ______________________________

______________________________

**Qualifying Event Information:**

Primary Beneficiary's Qualifying Event:
- ☐ Termination
- ☐ Reduction of hours
- ☐ Resignation/Retirement

Dependent Qualifying Event:
- ☐ Divorce or legal separation
- ☐ Death of covered employee
- ☐ Child no longer eligible

**Current COBRA**

**Paid Through Date:** ______________________________
(Date the beneficiary's COBRA premium is paid through)

**Date of the Qualifying Event:** ______________________________

**Pending COBRA**

**60-Day Election Period Begins:** ______________________________
(What date was the election letter sent?)

**45-Day Election Period Begins:** ______________________________
(What date was the election made?)

**Qualified Beneficiaries:**

- ☐ Employee Name: ____________________ Date of Birth: ____________________
- ☐ Spouse Name: ____________________ Date of Birth: ____________________
- ☐ Dep Child Name: ____________________ Date of Birth: ____________________
- ☐ Dep Child Name: ____________________ Date of Birth: ____________________
- ☐ Dep Child Name: ____________________ Date of Birth: ____________________
- ☐ Dep Child Name: ____________________ Date of Birth: ____________________

**Spouse or Dependent Address:**
(Complete if address is different than the primary beneficiary's address above)

______________________________

______________________________

**Health Plans:**

- ☐ Medical Carrier: ____________________ Rate Area: ____________________
- ☐ Dental Carrier: ____________________ Rate Area: ____________________
- ☐ Vision Carrier: ____________________ Rate Area: ____________________
- ☐ Other Plan/Carrier: ____________________ Rate Area: ____________________
- ☐ Section 125 Plan: ____________________ Election Amount and Balance: ____________________ (Amount) (Balance)

______________________________ (Signature of Employer or Employer Representative)

______________________________ (Date)

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# COBRA Notice of Qualifying Event

**Instructions:** To notify ASI of an employee who has lost coverage or has had a COBRA qualifying event, please return this completed form to our office. Our contact information is below.

**Employer Name:** ______________________

**Name of Primary Beneficiary:** ______________________ **Beneficiary's Social Security #:** ______________________

**First Date of Coverage:** ______________________ **Beneficiary's Mailing Address:** ______________________

______________________

**Qualifying Event Information:**

Primary Beneficiary's Qualifying Event: ☐ Termination ☐ Reduction of hours ☐ Resignation/Retirement

Dependent Qualifying Event: ☐ Divorce or legal separation ☐ Death of covered employee ☐ Child no longer eligible

**Date of the Qualifying Event:** ______________________
Date loss of coverage began or date of termination.

**Qualified Beneficiaries:**

☐ Employee Name: (COBRA Beneficiary) ______________________ Date of Birth: ______________________

☐ Spouse Name: ______________________ Date of Birth: ______________________

☐ Dep Child Name: ______________________ Date of Birth: ______________________

☐ Dep Child Name: ______________________ Date of Birth: ______________________

☐ Dep Child Name: ______________________ Date of Birth: ______________________

☐ Dep Child Name: ______________________ Date of Birth: ______________________

**Spouse or Dependent Address:**
Complete if address is different than the primary beneficiary's address above.

______________________

______________________

**Health Plans:**

☐ Medical Carrier: ______________________ Plan Name: ______________________

☐ Dental Carrier: ______________________ Plan Name: ______________________

☐ Vision Carrier: ______________________ Plan Name: ______________________

☐ Other Plan/Carrier: ______________________ Plan Name: ______________________

☐ Section 125 Plan: ______________________ Election Amount and Balance: ______________________
Amount Balance

______________________
Signature of employer or employer representative

______________________
Date

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