COBRA ADMINISTRATION INFORMATION

Please provide the following information for all applicable plans.

MERITAIN HEALTH
An Aetna Company

GROUP INFORMATION

Group Name: _____ **Group Contact Person:** _____

Group Contact Person Phone: _____ **Group Contact Person Email:** _____

Name of Previous COBRA Administrator: _____

Previous COBRA Administrator Contact Phone: _____

NEW MEDICAL PLAN INFORMATION – Protect Plans

Effective Date *(mm/dd/yy)*: _____ ☒ **Self-Funded**

	Plan 1	Plan 2	Plan 3	Plan 4
Plan Name:				
EE:	$	$	$	$
EE/ES:	$	$	$	$
EE/EC:	$	$	$	$
EE/FAM:	$	$	$	$

PRIOR MEDICAL PLAN INFORMATION

Termination Date *(mm/dd/yy)*: _____ ☐ **Fully Insured** ☐ **Self-Funded**

Carrier Name: _____ **Policy/Group #:** _____ **Plan Renewal** *(mm/dd)*: _____

Carrier Eligibility Contact Name: _____ **Carrier Eligibility Contact Phone:** _____

Carrier Eligibility Fax *(provide fax number the new COBRA Administrator would fax enrollment & terminations to)*: _____

Carrier Remittance Address: _____

City: _____ **State:** _____ **Zip Code:** _____

	Plan 1	Plan 2	Plan 3	Plan 4
Plan Name:				
EE:	$	$	$	$
EE/ES:	$	$	$	$
EE/EC:	$	$	$	$
EE/FAM:	$	$	$	$
	Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**	Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**	Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**	Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**

DENTAL PLAN INFORMATION

Effective Date *(mm/dd/yy)*: _____ ☐ **Fully Insured** ☐ **Self-Funded**

Carrier Name: _____ **Policy/Group #:** _____ **Plan Renewal** *(mm/dd)*: _____

Carrier Eligibility Contact Name: _____ **Carrier Eligibility Contact Phone:** _____

Carrier Eligibility Fax *(provide fax number the new COBRA Administrator would fax enrollment & terminations to)*: _____

Carrier Remittance Address: _____

City: _____ **State:** _____ **Zip Code:** _____

	Plan 1		Plan 2		Plan 3		Plan 4	
Plan Name:								
	Current Rates	*Rates Prior to Effc. Date*	*Current Rates*	*Rates Prior to Effc. Date*	*Current Rates*	*Rates Prior to Effc. Date*	*Current Rates*	*Rates Prior to Effc. Date*
EE:	$	$	$	$	$	$	$	$
EE/ES:	$	$	$	$	$	$	$	$
EE/EC:	$	$	$	$	$	$	$	$
EE/FAM:	$	$	$	$	$	$	$	$
	Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**		Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**		Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**		Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**	

VISION PLAN INFORMATION

Effective Date *(mm/dd/yy)*: _____ ☐ **Fully Insured** ☐ **Self-Funded**

Carrier Name: _____ **Policy/Group #:** _____ **Plan Renewal** *(mm/dd)*: _____

Carrier Eligibility Contact Name: _____ **Carrier Eligibility Contact Phone:** _____

Carrier Eligibility Fax *(provide fax number the new COBRA Administrator would fax enrollment & terminations to)*: _____

Carrier Remittance Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Plan Name:	**Plan 1**		**Plan 2**		**Plan 3**		**Plan 4**	
	Current Rates	*Rates Prior to Effc. Date*	*Current Rates*	*Rates Prior to Effc. Date*	*Current Rates*	*Rates Prior to Effc. Date*	*Current Rates*	*Rates Prior to Effc. Date*
EE:	$	$	$	$	$	$	$	$
EE/ES:	$	$	$	$	$	$	$	$
EE/EC:	$	$	$	$	$	$	$	$
EE/FAM:	$	$	$	$	$	$	$	$
	Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**		Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**		Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**		Do these rates include the 2% COBRA administration fee? ☐ **YES** ☐ **NO**	

Current COBRA Participants

Please provide the following information for each COBRA participant. If more than 2 participants, please use additional sheet.

COBRA PARTICIPANT 1

Name: _____

Qualifying Event Date *(mm/dd/yy)*: _____ **Qualifying Event Reason:** _____

MEDICAL PLAN -

Original COBRA Effective Date *(mm/dd/yy)*: _____ **Coverage Level** *(EE, ES, EC, FAM)*: _____

Plan Name: _____ **Premium Paid:** $ _____ **Premium Paid Through Date** *(mm/dd/yy)*: _____

DENTAL PLAN -

Original COBRA Effective Date *(mm/dd/yy)*: _____ **Coverage Level** *(EE, ES, EC, FAM)*: _____

Plan Name: _____ **Premium Paid:** $ _____ **Premium Paid Through Date** *(mm/dd/yy)*: _____

VISION PLAN -

Original COBRA Effective Date *(mm/dd/yy)*: _____ **Coverage Level** *(EE, ES, EC, FAM)*: _____

Plan Name: _____ **Premium Paid:** $ _____ **Premium Paid Through Date** *(mm/dd/yy)*: _____

COBRA PARTICIPANT 2

Name: _____

Qualifying Event Date *(mm/dd/yy)*: _____ **Qualifying Event Reason:** _____

MEDICAL PLAN -

Original COBRA Effective Date *(mm/dd/yy)*: _____ **Coverage Level** *(EE, ES, EC, FAM)*: _____

Plan Name: _____ **Premium Paid:** $ _____ **Premium Paid Through Date** *(mm/dd/yy)*: _____

DENTAL PLAN -

Original COBRA Effective Date *(mm/dd/yy)*: _____ **Coverage Level** *(EE, ES, EC, FAM)*: _____

Plan Name: _____ **Premium Paid:** $ _____ **Premium Paid Through Date** *(mm/dd/yy)*: _____

VISION PLAN -

Original COBRA Effective Date *(mm/dd/yy)*: _____ **Coverage Level** *(EE, ES, EC, FAM)*: _____

Plan Name: _____ **Premium Paid:** $ _____ **Premium Paid Through Date** *(mm/dd/yy)*: _____