HR Concepts, LLC

"Your Third Party Administrator of Choice"

COBRA EMPLOYER APPLICATION

Part I. Employer Information

Employer Name: ____

Mailing Address: __________________________ City: ______________________ St.: _____ Zip: ______

Street Address (if different): _________________ City: _______________________St: _____ Zip: ______

Telephone: __________________ Fax: _______________________ Tax Id #: _______________________

Primary Point of Contact: ________________ Phone Ext: ______Email: ____________________________

Secondary Point of Contact: ______________ Phone Ext: _______Email: ___________________________

Effective Date of COBRA Administration: ________________ Total Number of Employees:__________

Part II. Benefit Plan Description

Insurance Carrier: ______________________ Plan Name: ___________________ Medical / Dental / Vision

Insurance Carrier Contact: ________________ Phone#:______________ Fax #:_____________________

Renewal Date: ____________ Coverage Terminates: ___ Event Date ___ End of Month

ER Account #:____________ Group/Policy #:____________ Enroll #:______________ Fax #:____________

	Current Premium		COBRA Premium
EE Only	$_____________	(+ 2% Administration Fee) =	$______________
EE + Child	$_____________	(+ 2% Administration Fee) =	$______________
EE + Spouse	$_____________	(+ 2% Administration Fee) =	$______________
EE + Family	$_____________	(+ 2% Administration Fee) =	$______________

B. Insurance Carrier: ______________________ Plan Name: ___________________ Medical / Dental / Vision

Insurance Carrier Contact: ________________ Phone#:______________ Fax #:_____________________

Renewal Date: ____________ Coverage Terminates: ___ Event Date ___ End of Month

ER Account #:____________ Group/Policy #:____________ Enroll #:______________ Fax #:____________

	Current Premium		COBRA Premium
EE Only	$_____________	(+ 2% Administration Fee) =	$______________
EE + Child	$_____________	(+ 2% Administration Fee) =	$______________
EE + Spouse	$_____________	(+ 2% Administration Fee) =	$______________
EE + Family	$_____________	(+ 2% Administration Fee) =	$______________

C. Insurance Carrier: ______________________ Plan Name: ___________________ Medical / Dental / Vision

Insurance Carrier Contact: ________________ Phone#:______________ Fax #:_____________________

Renewal Date: ____________ Coverage Terminates: ___ Event Date ___ End of Month

ER Account #:____________ Group/Policy #:____________ Enroll #:______________ Fax #:____________

	Current Premium		COBRA Premium
EE Only	$_____________	(+ 2% Administration Fee) =	$______________
EE + Child	$_____________	(+ 2% Administration Fee) =	$______________
EE + Spouse	$_____________	(+ 2% Administration Fee) =	$______________
EE + Family	$_____________	(+ 2% Administration Fee) =	$______________

Phone: (603) 647-1147 • Fax: (603) 647-2329 • email: info@HRConcepts.biz
www.HRConcepts.biz • 9 Cedarwood Drive, Unit 8 • Bedford, NH 03110

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Part II. Benefit Plan Description (Continued)

D. Insurance Carrier: _________________________ Plan Name: ______________________ Medical / Dental / Vision
Insurance Carrier Contact: __________________ Phone#:________________ Fax #:________________________
Renewal Date: ______________ Coverage Terminates: ___ Event Date ___ End of Month
ER Account #:_____________ Group/Policy #:_____________ Enroll #:________________ Fax #:_____________

	Current Premium		COBRA Premium
EE Only	$_____________	(+ 2% Administration Fee) =	$______________
EE + Child	$_____________	(+ 2% Administration Fee) =	$______________
EE + Spouse	$_____________	(+ 2% Administration Fee) =	$______________
EE + Family	$_____________	(+ 2% Administration Fee) =	$______________

E. Insurance Carrier: _________________________ Plan Name: ______________________ Medical / Dental / Vision
Insurance Carrier Contact: __________________ Phone#:________________ Fax #:________________________
Renewal Date: ______________ Coverage Terminates: ___ Event Date ___ End of Month
ER Account #:_____________ Group/Policy #:_____________ Enroll #:________________ Fax #:_____________

	Current Premium		COBRA Premium
EE Only	$_____________	(+ 2% Administration Fee) =	$______________
EE + Child	$_____________	(+ 2% Administration Fee) =	$______________
EE + Spouse	$_____________	(+ 2% Administration Fee) =	$______________
EE + Family	$_____________	(+ 2% Administration Fee) =	$______________

F. Health Care Flexible Spending Account Carrier: _____________________ Renewal Date: ______________

Part III. General Information

____
____
____
____
____

Part IV. Signature and Fees

Broker: ________________ Broker pay Setup: ________ Renewal: _____________Letters:_______

Setup Fee: $___________ Fee for each Notification Letter: $____________ New Hire Letter: $ ______________
2% admin Fee Pd by participant: $___________

Renewal Fee: $_________ Fee for each Notification Letter: $____________ New Hire Letter: $ ______________
2% admin Fee Pd by participant: $___________

Authorized Signature of Employer: __________________________ Title: _____________________ Date: __________

Flex Plans • HSA's • Commuter Plans • HRA's • Dental Plans • COBRA

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