

## Paperwork Submission Instructions:

The following forms are to be completed and returned to CONEXIS

- Services Agreement and Fee Appendix
- New Business Application
- COBRA and HIPAA Attachment
- Carrier and Plan Information
- Division Contact Information (as applicable)

All forms may be returned via regular mail, fax, or e-mail to the following:

CONEXIS  
Attn: Sales  
721 S. Parker, Suite 300  
Orange, CA 92868

Fax: 714-347-3935  
E-mail: [mmcginnis@conexis.com](mailto:mmcginnis@conexis.com)

Upon receipt of your information, you will be contacted by your CONEXIS new business analyst within ten business days.

Please Mark the Services Purchased:  COBRA/HIPAA

**Section A – Employer Information**

Company Name		DBA (Doing Business As)	Federal Tax ID Number - FEIN
Address		Requested effective date	
City		State	Zip
Telephone Number	Fax number	Nature of Business	
( ) -	( ) -		

**Section B – Contact Information**

Contact Type	Contact Name	Title	Phone	Fax	E-mail	Web Access	Monthly Invoice
Executive			( ) -	( ) -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary COBRA			( ) -	( ) -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			( ) -	( ) -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other			( ) -	( ) -		<input type="checkbox"/> Read Only <input type="checkbox"/> Update <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section C – Data Exchange**

Encryption Method for confidential Information:  PGP ([www.pgpi.org/products/pgp/versions/freeware](http://www.pgpi.org/products/pgp/versions/freeware))  WinZip ([www.winzip.com](http://www.winzip.com))  
 In compliance with HIPAA Regulations, we require encryption of files submitted to CONEXIS or any files CONEXIS submits to our clients. If you use PGP to send files to CONEXIS, you will need to request our public key from [submissions@CONEXIS.com](mailto:submissions@CONEXIS.com). If you use PGP to receive files/reports, you will need to e-mail the text of your key to your New Business Analyst. **CONEXIS does not provide technical support for encryption software; please contact your network administrator for assistance.**

**Section D – Broker Information**

**Internal Use Only**

Broker Name	Broker of record for medical group? <input type="checkbox"/> Yes <input type="checkbox"/> No	Broker Code
Agency Name	Agency FEIN	
Address		
City	State	Zip
Phone	Fax	E-mail
( ) -	( ) -	

**Section E – HIPAA Authorization**

The following Named Contacts List identifies all individuals to whom CONEXIS may provide protected health information (PHI) in the performance of its duties as set forth in the Confidentiality Exhibit of the Administrative Services Agreement (Client may use additional pages if needed, provided they reference the Confidentiality Exhibit and the effective date):

Name:	Name:	Name:	Name:
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**Section F – Employer Representative – Form completed by:**

Name	Title	Phone Number
		( ) -

**Instructions:** Complete form in its entirety and return with the completed New Business Application

**Section A – General Information**

Company Name:

Number of Employees Eligible for Benefits:	Number of Eligible Employees as of (date):	Number of Employees Covered by Benefits:	Number of Current COBRA Continuants:
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Do you offer a Medical Reimbursement Flexible Spending Account? (If eligible a participant may continue a Medical FSAs through COBRA) <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you offer an HRA? (If eligible a participant may continue an HRA through COBRA) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are any of your COBRA continuants subject to the following:  
 HCTC (Health Coverage Tax Credit)  CalCOBRA  Other state continuation coverage (please explain)

Do you want to charge the allowable 150% for COBRA participants on the 11-month disability extension?  Yes  No

**Section B – Carrier and Plan Information.** Complete a separate Carrier and Plan Information Form for each employer sponsored group health plan subject to COBRA.

**Section C – Previous COBRA Administrator**

Company Name	Contact Name
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Address

City	State	Zip
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Telephone Number ( ) -	Fax Number ( ) -	E-Mail
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Can CONEXIS contact the previous COBRA administrator?  Yes  No

**Section D – COBRA Premium and Eligibility Reporting**

Which contact person listed on the New Business Application is the recipient of the monthly COBRA premiums (typically the primary contact)

Will CONEXIS communicate/distribute eligibility and or premium to carriers? (if yes to any, please fill out the appropriate contact information on the Carrier and Plan Information Form, **\*additional fees may apply**)

**PREMIUM REMITTANCE TO CARRIERS NOT AVAILABLE TO EMPLOYERS WITH LESS THAN 500 EMPLOYEES**

Premium to carriers:  Yes  No      Eligibility to carriers:  Yes  No

List client contacts to receive copies of the COBRA eligibility reports (you will be contacted to determine type and frequency)

Contact Name	E-mail Address	Phone	Fax

**Employer Representative – Form completed by:**

Name	Title	Phone Number ( ) -
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**Instructions:** Complete form for each employer-sponsored group health plan subject to COBRA. Use a separate form for each plan with a unique set of rates and/or group number. Return this form with the completed New Business Application.

**Section A – Plan Information**

Employer Name		Carrier Name			
Group Number	Dependent Children Age Limit	Full-Time Student Age Limit			
Plan Effective Date:	Plan Renewal Date	Is there a Waiting Period <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long? _____ <input type="checkbox"/> Days <input type="checkbox"/> Months	Following the waiting period, coverage is effective <input type="checkbox"/> Immediately <input type="checkbox"/> Next Day <input type="checkbox"/> First of the Month	
Coverage ceases					
<input type="checkbox"/> Date of termination <input type="checkbox"/> End of month <input type="checkbox"/> Next Day after Termination <input type="checkbox"/> 15 <sup>th</sup> of the Month <input type="checkbox"/> Other					
Plan Name		Is this plan 'bundled' together with other plans (participants are required to elect all plans to continue coverage)? If yes, list plan names			

Plan Type (Mark all boxes that apply)

Medical  
  Dental  
  Vision  
  Rx  
  Medical FSA  
  Self Funded  
  Fully Insured  
  HMO  
  PPO  
  POS  
  Indemnity

**Section B – Carrier Eligibility Contact** – Complete only if CONEXIS will communicate eligibility to your carriers. If the eligibility and billing contact information has been provided for this carrier on a separate form, mark 'Previously Provided' in the contact name field.

Eligibility Contact Name		Customer Service Toll Free Number ( ) -	
Address			
City		State	Zip
Telephone Number ( ) -		Fax Number ( ) -	E-mail

**Section C – Carrier Billing Contact** – Complete only if optional premium remittance to carriers has been purchased.

Contact Name			
Address to send payments			
City		State	Zip
Telephone ( ) -		Fax Number ( ) -	E-mail

**Section D – Rates**

Rates – Do not include the 2% COBRA Administrative Fee							
Employee	Employee + Spouse	Employee + Child(ren)	Spouse Only	Spouse + Child(ren)	Children Only	Child Only	Family
Rates (if 3-tier structure) - Do not include the 2% COBRA Administrative Fee							
Individual Only		Individual + 1			Individual + 2 or more		

**Section E – Employer Representative** – Form completed by:

Name	Title	Phone Number

