



COBRA Employer Application Form

Company Name: _____ Tax ID: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Name: _____ Contact Title: _____

Contact Phone: _____ Contact Email: _____

Current COBRA Administrator: _____ We currently administer our COBRA plan in-house

Administrator Address: _____

Account Manager Name: _____ Phone Number: _____

Number of Full-Time Employees: _____

Number of Insured Under Medical Plan: _____

COBRA Administrative Plan Options

Our standard package of COBRA services includes:

- Takeover of COBRA continuants
- Election packets for new qualified beneficiaries
- Welcome Packet (includes letter explaining benefits and a coupon booklet)
- Acceptance of QB payments by check or recurring ACH
- Monthly reporting and remittance of premiums to employer by check or ACH
- Website access to account for the employer and all QBs

Optional Services: (Additional annual fees apply)

- Remittance of monthly premiums to carrier plus auditing and reconciliation of carrier statements
- Notify carriers of COBRA elections and terminations
- Management of open enrollment for qualified beneficiaries

Producer/Broker/Agency Information

Producer/Broker Name: _____ Agency Name: _____

Producer/Broker Phone: _____ Producer/Broker Email: _____

General Agency: _____

Fee Information

Please have your Sterling HSA Sales Representative complete the following information.

Annual Set-up Fee: _____

Optional Services Fees: _____

Total Annual Fees: _____

Banking Information

Sterling Health Services Administration will deduct your annual COBRA administration fees from this account. If you wish, we will also remit the monthly premiums to this account in lieu of a check by mail. By providing the information below, you are authorizing Sterling Health Services Administration to initiate entries to your checking/savings account at the financial institution listed below and, if necessary, initiate adjustments for any transactions credited/debited in error. All entries are related to the COBRA administration your company has established with Sterling Health Services Administration. This authority will remain in effect until Sterling Health Services Administration is notified by you in writing to cancel it in such time as to afford Sterling Health Services Administration and the financial institution named below a reasonable opportunity to act on it. **You must attach a copy of a voided check to this application as part of this process.**

Financial Institution Name: _____

Financial Institution Routing Number: _____

Banking Account Number: _____

Checking Savings

If monthly premiums will be remitted to employer, would you like us to credit these payments to this account via ACH?

Yes No

Application Agreement / Signature

We, the undersigned employer, affirm the accuracy of this application and acknowledge that this application can be relied upon for the preparation of the COBRA Administration Agreement with Sterling Health Services Administration. We also agree to indemnify Sterling Health Services Administration and hold Sterling Health Services Administration harmless against any and all loss, damage or lawsuits brought against Sterling Health Services Administration to recover benefits under the plan, unless such actions arise out of the willful act or negligence of Sterling Health Services Administration.

Form Completed By: _____

Name (Print): _____

Date: _____ Phone: _____ Fax: _____

Signature: _____

Benefit Plan Information

Note: Employers must complete a Benefit Plan Form (below) for each COBRA-eligible benefit plan. The Benefit Plan Form is repeated 3 times below. If you have more than 3 COBRA-eligible benefit plans and need more forms, please make copies of this part of the COBRA application and attach additional completed Benefit Plan Forms.

Insurance Company: _____ Plan Name: _____

Plan Type: Medical Dental Vision Flex Other: _____

State Governing Plan: _____ Is plan self-funded? Yes No

Plan Start Date: _____ Plan End Date: _____

Coverage Renewal Period: _____ Does plan allow for conversion? Yes No

When does employee coverage terminate after a COBRA qualifying event? Event Date End of Month

Is this plan age rated? Yes No If yes, please attach age rate table. If no, please use table below, or attach plan rate table.

Current Premium	COBRA Premium
Employee Only _____ (+2% Admin Fee) = _____	_____
Employee + Spouse _____ (+2% Admin Fee) = _____	_____
Employee + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____	_____ / _____
Employee + Family _____ (+2% Admin Fee) = _____	_____
Spouse Only _____ (+2% Admin Fee) = _____	_____
Child(ren) Only _____ / _____ (+2% Admin Fee) = _____ / _____	_____ / _____
Spouse + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____	_____ / _____

This area only needed if Optional Services are elected. If no optional services elected, leave blank.

Carrier Contact Name: _____ Policy/Group Number: _____ Plan Number: _____

Carrier Remittance Address: _____

Contact Email: _____ Contact Phone: _____

Insurance Company: _____ Plan Name: _____

Plan Type: Medical Dental Vision Flex Other: _____

State Governing Plan: _____ Is plan self-funded? Yes No

Plan Start Date: _____ Plan End Date: _____

Coverage Renewal Period: _____ Does plan allow for conversion? Yes No

When does employee coverage terminate after a COBRA qualifying event? Event Date End of Month

Is this plan age rated? Yes No If yes, please attach age rate table. If no, please use table below, or attach plan rate table.

Current Premium

COBRA Premium

Employee Only _____ (+2% Admin Fee) = _____

Employee + Spouse _____ (+2% Admin Fee) = _____

Employee + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____

Employee + Family _____ (+2% Admin Fee) = _____

Spouse Only _____ (+2% Admin Fee) = _____

Child(ren) Only _____ / _____ (+2% Admin Fee) = _____ / _____

Spouse + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____

This area only needed if Optional Services are elected. If no optional services elected, leave blank.

Carrier Contact Name: _____ Policy/Group Number: _____ Plan Number: _____

Carrier Remittance Address: _____

Contact Email: _____ Contact Phone: _____

Insurance Company: _____ Plan Name: _____

Plan Type: Medical Dental Vision Flex Other: _____

State Governing Plan: _____ Is plan self-funded? Yes No

Plan Start Date: _____ Plan End Date: _____

Coverage Renewal Period: _____ Does plan allow for conversion? Yes No

When does employee coverage terminate after a COBRA qualifying event? Event Date End of Month

Is this plan age rated? Yes No If yes, please attach age rate table. If no, please use table below, or attach plan rate table.

Current Premium

COBRA Premium

Employee Only _____ (+2% Admin Fee) = _____

Employee + Spouse _____ (+2% Admin Fee) = _____

Employee + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____

Employee + Family _____ (+2% Admin Fee) = _____

Spouse Only _____ (+2% Admin Fee) = _____

Child(ren) Only _____ / _____ (+2% Admin Fee) = _____ / _____

Spouse + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____

This area only needed if Optional Services are elected. If no optional services elected, leave blank.

Carrier Contact Name: _____ Policy/Group Number: _____ Plan Number: _____

Carrier Remittance Address: _____

Contact Email: _____ Contact Phone: _____

Insurance Company: _____ Plan Name: _____

Plan Type: Medical Dental Vision Flex Other: _____

State Governing Plan: _____ Is plan self-funded? Yes No

Plan Start Date: _____ Plan End Date: _____

Coverage Renewal Period: _____ Does plan allow for conversion? Yes No

When does employee coverage terminate after a COBRA qualifying event? Event Date End of Month

Is this plan age rated? Yes No If yes, please attach age rate table. If no, please use table below, or attach plan rate table.

Current Premium

COBRA Premium

Employee Only _____ (+2% Admin Fee) = _____

Employee + Spouse _____ (+2% Admin Fee) = _____

Employee + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____

Employee + Family _____ (+2% Admin Fee) = _____

Spouse Only _____ (+2% Admin Fee) = _____

Child(ren) Only _____ / _____ (+2% Admin Fee) = _____ / _____

Spouse + Child(ren) _____ / _____ (+2% Admin Fee) = _____ / _____

This area only needed if Optional Services are elected. If no optional services elected, leave blank.

Carrier Contact Name: _____ Policy/Group Number: _____ Plan Number: _____

Carrier Remittance Address: _____

Contact Email: _____ Contact Phone: _____

Form Completed By: _____

Name (Print): _____

Date: _____ Phone: _____ Fax: _____

Signature: _____