AmeriHealth ADMINISTRATORS

COBRA/RETIREE NEW CLIENT IMPLEMENTATION FORM

GENERAL INFORMATION

Group Name:_____

COBRA Effective Date:_____

Previous COBRA Administrator:_____

PRIMARY GROUP/PLAN CONTACT

Name:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

Is this individual also the contact for billing?

☐ Yes ☐ No

If the billing contact differs from the Group/Plan contact, record the billing contact's info in the CONTACT INFORMATION section, page 2.

TERMINATION METHOD

When does the qualified beneficiary group coverage end?

☐ End of Month after term date ☐ Exact Termination Date

If exact termination date, is last month of COBRA extended to the end of the month?

☐ Yes ☐ No

Do these selections apply to all of the client's plans and coverages?

☐ Yes ☐ No

If different termination methods apply for dependents or across different plans, please explain those rules:

SEVERANCE

Does severance period run concurrent or separate from COBRA?

☐ Concurrent ☐ Separate

Is AHA to mail a separate severance letter with COBRA Notification?

☐ Yes ☐ No

Do all benefits (Medical/Dental/Vision/Rx) apply to severance?

☐ Yes ☐ No

If "No," please explain:

Must AHA receive all enrollment forms before activating COBRA?

☐ Yes ☐ No

Are there any other special severance instructions?

☐ Yes ☐ No

If "Yes," please explain:

SERVICES SELECTED BY THE CLIENT

☐ COBRA Administration

☐ Carrier payments on client's behalf

If Yes, all carrier bills must go directly to AHA.

☐ Initial Department of Labor (DOL) Notices

☐ Early Retiree Billing (up to age 65)

☐ Retiree Billing (65 and over)

☐ Long Term Disability (LTD)

☐ DU31 Billing (NJ plans; dependents to 31)

MEDICARE ENTITLEMENT

Does an active employees' Medicare entitlement cause family members to lose coverage under the active group health plan?

☐ Yes ☐ No

Does the client consider Medicare entitlement a secondary qualifying event although it does not cause family members to lose benefits?

☐ Yes ☐ No

HEALTH FLEXIBLE SPENDING ACCOUNTS

Does the client offer an FSA program?

☐ Yes ☐ No

If Yes, complete the following questions:

Who is the FSA vendor?_____

If the client uses a vendor other than AHA, list the FSA vendor name and contact information.

Vendor name:_____

Address:_____

City, State, Zip:_____

SOCIAL SECURITY EXTENSION FEE

Enter the social security extension fee percentage from 2% through 50%:

RETIREE BILLING (OPTIONAL)

When does retiree coverage end?

☐ 1st of month of 65th birthday

☐ 1st of month following 65th birthday

☐ Indefinitely

Should the 2% participant fee be added to retiree rates?

☐ Yes ☐ No

Retiree special instructions:

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MONTHLY INVOICING

What are the administration fees that the client pays to AHA?

Administrative fee _____

DOL Notice fee _____

Carrier remittance fee_____

Implementation fee _____

Minimum monthly fee_____

Who retains the 2% fee charges to the participant?

☐ AHA

☐ Client

How will the client remit the invoiced amounts?

☐ ACH transfer (preferred method)

☐ Check

☐ Special invoice process, please explain:

OTHER GROUP-SPECIFIC PROCESSES

Can participants select benefits "a la carte"?

☐ Yes ☐ No

Describe any other group-specific processes:

CONTACT INFORMATION

Give contact information for anyone, in addition to the Group/Plan Contact identified on page 1, who should be notified of enrollments, terminations, changes, etc:

Name:_____

Address:_____

Phone:_____Fax:_____

Email:_____

Billing contact?

☐ Yes ☐ No

Name:_____

Address:_____

Phone:_____Fax:_____

Email:_____

Billing contact?

☐ Yes ☐ No

Name:_____

Address:_____

Phone:_____Fax:_____

Email:_____

Billing contact?

☐ Yes ☐ No

Name:_____

Address:_____

Phone:_____Fax:_____

Email:_____

Billing contact?

☐ Yes ☐ No

AmeriHealth ADMINISTRATORS

COBRA/RETIREE NEW CLIENT IMPLEMENTATION FORM

RATE SHEET

MEDICAL

Maximum Dependent Age: _____

Medical Carrier: _____ Medical Group Number: _____ Medical COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

DENTAL

Maximum Dependent Age: _____

Dental Carrier: _____ Dental Group Number: _____ Dental COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

VISION

Maximum Dependent Age: _____

Vision Carrier: _____ Vision Group Number: _____ Vision COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

AmeriHealth ADMINISTRATORS

COBRA/RETIREE NEW CLIENT IMPLEMENTATION FORM

RATE SHEET

PRESCRIPTION

Maximum Dependent Age: _____

Rx Carrier: _____ Rx Group Number: _____ Rx COBRA Group Number: _____

Plan Rate Renewal Date: _____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email: _____

Plan name: _____	Plan name: _____	Plan name: _____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse: _____	Single/spouse: _____	Single/spouse: _____
Single/child: _____	Single/child: _____	Single/child: _____
Single/children: _____	Single/children: _____	Single/children: _____
Family: _____	Family: _____	Family: _____

EMPLOYEE ASSISTANCE PROGRAM

EAP Carrier: _____ EAP Group Number: _____ EAP COBRA Group Number: _____

Plan Rate Renewal Date: _____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email: _____

Plan name: _____	Plan name: _____	Plan name: _____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse: _____	Single/spouse: _____	Single/spouse: _____
Single/child: _____	Single/child: _____	Single/child: _____
Single/children: _____	Single/children: _____	Single/children: _____
Family: _____	Family: _____	Family: _____

FORM COMPLETED BY

Name: _____ Company: _____

Title: _____ Email: _____

Phone: _____ Fax: _____

RATE SHEET

MEDICAL

Maximum Dependent Age: _____

Medical Carrier: _____ Medical Group Number: _____ Medical COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

DENTAL

Maximum Dependent Age: _____

Dental Carrier: _____ Dental Group Number: _____ Dental COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

VISION

Maximum Dependent Age: _____

Vision Carrier: _____ Vision Group Number: _____ Vision COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

RATE SHEET

PRESCRIPTION

Maximum Dependent Age: _____

Rx Carrier: _____ Rx Group Number: _____ Rx COBRA Group Number:_____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method:_____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

EMPLOYEE ASSISTANCE PROGRAM

EAP Carrier: _____ EAP Group Number: _____ EAP COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

RATE SHEET

MEDICAL

Maximum Dependent Age: _____

Medical Carrier: _____ Medical Group Number: _____ Medical COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

DENTAL

Maximum Dependent Age: _____

Dental Carrier: _____ Dental Group Number: _____ Dental COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

VISION

Maximum Dependent Age: _____

Vision Carrier: _____ Vision Group Number: _____ Vision COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

RATE SHEET

PRESCRIPTION

Maximum Dependent Age: _____

Rx Carrier: _____ Rx Group Number: _____ Rx COBRA Group Number:_____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method:_____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____

EMPLOYEE ASSISTANCE PROGRAM

EAP Carrier: _____ EAP Group Number: _____ EAP COBRA Group Number: _____

Plan Rate Renewal Date:_____ ☐ Insured ☐ Self Insured Termination Method: _____

Contact Name: _____ Contact Phone: _____ Fax: _____ Email:_____

Plan name:_____	Plan name:_____	Plan name:_____
2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No	2% fee included: ☐ Yes ☐ No
Enter rates	***Enter rates***	***Enter rates***
Single: _____	Single: _____	Single: _____
Single/spouse:_____	Single/spouse:_____	Single/spouse:_____
Single/child:_____	Single/child:_____	Single/child:_____
Single/children:_____	Single/children:_____	Single/children:_____
Family:_____	Family:_____	Family:_____