SMALL BUSINESS Association of MICHIGAN | SMALL BUSINESS INSURANCE SERVICES

COBRA ADMINISTRATION ENROLLMENT FORM

Member Company **Not** Enrolled In SBAM-Sponsored BCBSM / BCN

Please complete this enrollment form in its entirety. Incomplete information will result in the delay of administering COBRA for your company.

Company Information

Company Name:		
Contact Person: ☐ Mr. ☐ Ms. First Name:	Last Name:	
Title:		
Mailing Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	
E-Mail Address:		
Total Number of Subscribers:		

Health Insurance Agent Information

First Name:	Last Name:
Agency:	
Agent Phone Number:	
Agent Email Address:	

Please choose one of the following:	
☐ Company with up to 100 subscribers	$60 per month or $720 per year
☐ Company with more than 100 subscribers	$75 per month or $900 per year

Please choose your payment options:

Administrative Fee Billing Interval: ☐ Monthly ☐ Annually

☐ Please check this box if the invoice should be mailed to the insurance agent rather than the Member Company.

COBRA RIGHTS AND RESPONSIBILITIES

Notice and Election Procedures

COBRA Regulations require a group health plan to provide covered employees and their families with certain notices explaining their COBRA rights. Group health plans must also have rules for how COBRA continuation coverage is offered, how qualified beneficiaries may elect continuation coverage and when it can be terminated.

COBRA General Notice – Continuation Coverage Rights Under COBRA

Group health plans must give each employee and each spouse who becomes covered under your plan a General Notice describing COBRA rights. Small Business Insurance Services (SBIS) calls this letter the **Continuation Coverage Rights Under COBRA.** By Department of Labor regulation, **this notice must be provided within the first 90 days of coverage**. This notice must contain the information that a covered employee or spouse needs to know in order to protect their COBRA rights when they first become covered under the plan, including the name of the plan and someone they can contact for more information, a general description of the continuation coverage provided under the plan, and an explanation of any notices the covered employee or spouse must give to the plan to protect their COBRA rights.

Following the completion of all required documents and the execution of the Group COBRA Administration Agreement, if necessary, SBIS will provide each employee with the required Continuation Coverage Rights Under COBRA letter.

NOTE: If the company's subscribers and dependents have already received the General Notice, it DOES NOT need to be sent again.

Do you need SBIS to send the General Notice to your current subscribers? Select one of the following:

☐ **YES**, please send the General Notice ☐ **NO**, please DO NOT send the General Notice

*If you selected 'YES', please provide us with a list of names and addresses for current subscribers and their dependents.

HEALTH PLAN INFORMATION

Medical Carrier(s) _____ Group Number(s) _____

_____ _____

_____ _____

Dental Carrier _____ Group Number _____

☐ check box if the dental is a stand-alone policy

Vision Carrier _____ Group Number _____

☐ check box if the vision is a stand-alone policy

HRA Carrier _____ Group Number _____

When does insurance coverage end? Please choose one: ☐ **End of the month** ☐ **Last day of employment**

Please Insert Rate Sheets For All Carriers

CURRENT COBRA PARTICIPANTS (Attach Additional Sheets if Necessary)

COBRA Participant #1 First Name: MI: Last Name:		
Address:		
City:	State:	Zip:
Original COBRA Qualifying Date:	**Premium Paid Through Date:**	**Premium Amount $**
Type of Qualifying Event (i.e. death, divorce, etc):		
Social Security Number:	DOB:	
Spouse First Name: MI: Last Name:		
Social Security Number:	DOB:	
Dependent #1 First Name: MI: Last Name:		
Social Security Number:	DOB:	
Dependent #2 First Name: MI: Last Name:		
Social Security Number:	DOB:	
Dependent #3 First Name: MI: Last Name:		
Social Security Number:	DOB:	

Medical Carrier	**Group No./Suffix**	**Premium Amount (without 2% COBRA fee)**	**Premium Paid Through Date**
Dental Carrier	**Group No./Suffix**	**Premium Amount (without 2% COBRA fee)**	**Premium Paid Through Date**
Vision Carrier	**Group No./Suffix**	**Premium Amount (without 2% COBRA fee)**	**Premium Paid Through Date**

Effective Date of COBRA Administration

If all required completed information is received prior to the 15th of the month, administrative service will begin on the 1st of the following month. If all information is received after the 15th of the month, then administrative service will begin on the 1st of the month following a 30-day grace period.

Required completed information includes:

1. A completed SBAM Membership Application and payment (or satisfactory evidence of payment) by Group of SBAM's first-year membership dues, unless Group is a current member in good standing with SBAM;

2. A completed COBRA Enrollment Form;

3. A completed and executed Group Census Form, which includes names, social security numbers, addresses, and dates of birth for each subscriber and subscriber's covered dependents;

4. Current, renewal, or new carrier premium rates for all insurance carriers (including any stand-alone dental, vision or prescription plans) with which Group plan subscribers are enrolled, as well as the corresponding Group numbers for each carrier;

5. An executed copy of original of Agreement; and

6. To the extent that Group has current COBRA subscribers, information for each such subscriber and dependents including qualifying event date, date of COBRA notification, date of COBRA enrollment premium rates at the time of COBRA enrollment, and paid-to-date information.

Date to begin COBRA administration:

month year

Membership & Plan Changes

☐ **YES,** our Group wants to be solely responsible for transmitting or otherwise submitting all Group membership and plan changes to the appropriate COBRA Insurance Program. Group acknowledges that Small Business Insurance Services (SBIS) has no liability to Group or any covered individual for Group's failure to submit Group membership and plan changes to the appropriate COBRA Insurance Program or for Group's failure to accurately and timely provide such information to the appropriate Group Insurance Program. If a covered individual enrolls in a COBRA Insurance program prior to Group providing complete and accurate necessary enrollment forms or premium to the appropriate Group Insurance Program, then group shall be liable to pay any applicable premium. SBIS shall presume that all information provided to the appropriate Group Insurance Program by GROUP is complete and accurate and SBIS has no obligation to question or verify the completeness or accuracy of the information provided by Group.

☐ **NO**, our Group wants Small Business Insurance Services (SBIS) to handle all membership and plan changes.

*** BEFORE SIGNING BELOW, please review the enrollment form and ensure you have all of the fields completely filled out.**

Please type or sign your name below to represent your approval of the information provided.

Printed Name / Signature: / _____

Title:

Date:

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