

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: _____

Billing Point of Contact: _____ Phone Ext: _____ Email: _____

Effective Date of COBRA Administration: _____ Total Number of Employees: _____

Part II. Plan Description

A. Insurance Carrier: _____ Plan Name: _____ Medical/ Dental / Vision
Insurance Carrier Contact: _____ Phone#: _____ Fax#: _____
Renewal Date: _____ Coverage Terminates: _____ Event Date _____ End of Month
Group/Policy #: _____ Enroll #: _____ Fax #: _____

	Current Premium		COBRAPremium
EE Only	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Spouse	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Child	\$ _____	(+ 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
Group/Policy #: _____ Enroll #: _____ Fax #: _____

	Current Premium		COBRAPremium
EE Only	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Spouse	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Child	\$ _____	(+ 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
Group/Policy #: _____ Enroll #: _____ Fax #: _____

	Current Premium		COBRAPremium
EE Only	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Spouse	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Child	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Family	\$ _____	(+ 2% Administration Fee) =	\$ _____



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

Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrconcepts.biz

www.HRConcepts.biz • 111 Charles Street • Manchester, NH 03101

HR Concepts, LLC

"Your Third Party Administrator of Choice"

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
Group/Policy #: _____ Enroll #: _____ Fax #: _____

	Current Premium		COBRAPremium
EE Only	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Spouse	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Child	\$ _____	(+ 2% Administration Fee) =	\$ _____
EE + Family	\$ _____	(+ 2% Administration Fee) =	\$ _____

E. Health Care Flexible Spending Account Carrier: _____ RenewalDate: _____

F. Health Care Reimbursement Account Carrier: _____ RenewalDate: _____
Are you charging for HRA: Yes No
If Yes, amount charging:

EE Only:	_____	██████EĞÄ Ćĉ{ ħ Ćĉ^DVAÄ	██████
EE + Spouse:	_____	██████EĞÄ Ćĉ{ ħ Ćĉ^DVAÄ	██
EE + Child:	_____	██████EĞÄ Ćĉ{ ħ Ćĉ^DVAÄ	
EE + Family:	_____	██████EĞÄ Ćĉ{ ħ Ćĉ^DVAÄ	

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

Phone: 603-647-1147 • Fax: 1-866-978-7868 • email: info@hrconcepts.biz

www.HRConcepts.biz • 111 Charles Street • Manchester, NH 03101