Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

Premium Collection Services Installation Questionnaire

EMPLOYER INFORMATION:

1. Employer (legal business name with correct punctuation): _____
   *(**NOTE:** A corporate name must end in "Incorporated", "Corporation" or "Limited", or an abbreviation of same)*

2. Street Address: _____

   City, State, Zip Code: _____

3. Contact Information:

	Contact #1	Contact #2	Contact #3
Name			
Title			
Phone			
E-mail			
Online Access?	□ Yes □ No	□ Yes □ No	□ Yes □ No

4. Tax ID Number:

		-							

5. Number of Eligible Employees: _____

6. Type of Business Entity:

	Sole Proprietorship		Partnership or LLP
	Corporation		Non-Profit
	S- Corporation		LLC
	Government Entity		Other: _____

7. Other than the entity identified in '1' above, please list the name, address and employer identification number of any other employers whose employees are to be eligible for this Plan:

NAME	ADDRESS	TAX ID

Please complete a separate information page for each plan that Pro-Flex Administrators will administer Premium Collection Services for.

TYPE OF POLICY:

□ Medical □ Vision

□ Dental □ EAP (Stand-alone plans only)

INSURANCE COMPANY/ PLAN INFORMATION:

8. Insurance Carrier Name:_____

   Insurance Customer Service Phone Number: _____

9. Insurance Carrier Account Manager Name:_____

   Email Address for Account Manager: _____

10. Carrier Email Address for Enrollment/Terminations/Changes:_____

(All notifications are system emailed directly to carriers. If carrier information is not provided, notifications will be sent to the client for processing)

11. Insurance Plan Name: _____

   a. Insurance Plan Number for Cobra (Sub) Group: _____

   b. First day of contract year: ___/___/___

   c. Last day of contract year: ___/___/___

   d. State where policy was written: _____

12. On what day does termination from the plan become effective?

   □ Date of Termination □ End of month

   □Other (Please Describe): _____

13. Rates:

   Single: _____

   Employee+ Spouse: _____

   Employee + Child(ren): _____

   Family: _____

14. If this is a medical plan, is this plan a self-funded ERISA Plan?

   □ Yes □ No

   If yes, and a medical plan, please indicate the duration of COBRA:

   □ 18 months □ 36 months

15. Does coverage terminate upon Medicare entitlement?

   □ Yes □ No

** Please note all COBRA Premiums are remitted to the client monthly. Payment will be remitted with all applicable backup and detailed breakdown of premiums**

16. Are there any current Premium Collection Members?

□ Yes *(Please complete a separate Notification Form for all current members)* ☐ No

BANKING/FUNDING AND FEES:

17. If applicable, which pricing option are you choosing?

□ Per Event □ Per Eligible Per Month

18. How will the client remit fee payments to Pro-Flex Administrators, LLC:

□ Manual Check □ ACH Withdraw (Client will need to complete Electronic Payment Authorization)

19. Who will be paying the Monthly COBRA Administrative fees?

□ Client □ Broker □ Member

I have read and understand the Premium Collection Proposal provided by Pro-Flex Administrators. I understand all collected premiums will be remitted to the client at the address listed on page one monthly. Pro-Flex will handle all enrollments/terminations, collection of employee applications (if applicable) and premiums as outlined in the forthcoming Service Agreement.

Group Signature: _____ Date:_____

BROKER INFORMATION:

Contact Name and Agency: _____

Contact Title: _____

Signature: _____ Date:_____

Submit to: Pro-Flex Administrators, LLC, 8321 Main Street, Williamsville, NY 14221

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