Pro-Flex
PRO-FLEX ADMINISTRATORS LLC

COBRA 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	Broker (optional)
Name			
Title			
Phone			
E-mail			
Online Access	□ Yes □ No	□ Yes □ No	□ Yes □ No

4. Tax ID Number:

		-							

5. Number of Employees_____

6. Number of Benefit Eligible Employees_____

7. Number of Employees Enrolled_____

8. Type of Business Entity:

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

9. 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 note all premiums are remitted via ACH once monthly. Backup will be available online

Please complete a separate information page for each carrier plan Pro-Flex Administrators will administer COBRA for.

TYPE OF POLICY:

□ Medical
□ Dental
□ Vision
□ EAP (Stand-alone plans only)
□ HRA
□ FSA

INSURANCE COMPANY/ PLAN INFORMATION:

10. Insurance Carrier Name: _____

11. Insurance Carrier Account Manager Name: _____

Email Address: _____

Email Address(es) for Automated Emails: _____

_____

(Automated emails regarding reinstatement, changes and terminations will be sent to this email address. Please be sure the email listed above can accept Transport Layer Security (TLS) emails. This should be a carrier email address. If carrier information is not provided, notifications will be sent to the client for processing)

12. 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: _____

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

□ Date of Termination
□ Wash Roll Rule
□ End of Month

14. Rates:

Single: _____

Employee+ Spouse: _____

Employee + Child(ren): _____

Family: _____

Other: _____

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

□ Yes (see below)
□ No

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

□ 18 months
□ 36 months

16. Does coverage terminate upon Medicare entitlement?

□ Yes
□ No

Please note all premiums are remitted via ACH once monthly. Backup will be available online

CURRENT CONTINUEES:

17. Are there any current COBRA continuants?

□ Yes *(Please complete a COBRA Legacy Notification Form for each current continuee)* □ No

BANKING/FUNDING AND FEES:

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

□ Per Event □ Per Eligible Per Month

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

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

20. Who should Pro-Flex email the invoice to for the monthly Administrative fees?

□ Client □ Broker

Email Address(es) for Invoice (up to two): _____

I have read and understand the COBRA Proposal provided by Pro-Flex Administrators. I understand all collected premiums will be remitted to the client via ACH once monthly. Pro-Flex will handle all COBRA enrollments/terminations. Collection of employee applications (if applicable) and premiums as outlined in the forthcoming Service Agreement.

Group Signature: _____ Date:_____

***Please note:** Signature on this document is an agreement to pay Pro-Flex Administrators LLC all applicable fees described in detail in the proposal. Failure to pay fees may result in a halt of implementation and/or services.*

BROKER INFORMATION:

Contact Name and Agency: _____

Contact Title: _____

Signature: _____ Date:_____

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

Please note all premiums are remitted via ACH once monthly. Backup will be available online

Electronic Receipt Authorization

Pro-Flex Administrators LLC provides cobra benefit administration services to_____ and/or, one or more of its wholly owned subsidiaries.

_____ desires the flexibility to receive payments for such services by electronic funds transfers (EFT) through the ACH Network.

Therefore, _____hereby (1) authorizes Pro-Flex Administrators LLC to send payments for those services by EFT, (2) certifies that it has selected the following depository financial institution, and (3) directs that all such electronic funds transfers be made as provided below:

Depository Institution Name: _____

Routing Transit Number: _____

Account Number: _____

ACH Payment Format: CCD will be used (Cash Concentration/Disbursement)

Company EFT Contact: _____

Secondary Contact: _____

Email addresses (both contacts):
_____
_____

_____, acknowledges and agrees that the terms and conditions of all agreements with Pro-Flex Administrators LLC concerning the method and timing of payments for services shall be amended as provided herein.

Company will give thirty (30) days advanced, written notice to Pro-Flex Administrators LLC of any changes in depository financial institution or other payment instructions.

When properly executed, the Authorization will become effective fifteen (15) days after its receipt by Pro-Flex Administrators LLC.

NAME OF COMPANY: _____

BY: _____

TITLE: _____ DATE: _____