COBRA Retiree Billing

Premium Collection Form

Company Name _____ Client TASC ID: _____

Branch: _____

If you have multiple branches, subsidiaries, or locations and offer different benefit plans/premiums for each, please complete a separate form for each group.

PLEASE NOTE: To maintain compliance with federal law, TASC COBRA requires that any changes in rates must be submitted to TASC by the 15th of the month prior to the effective date. Failure to supply any changes in rates by this deadline will result in a delay of the effective date for the rate change. If received after the 15th of the month prior, implementation will be delayed at least until the first of the month following the month for which rates were received (ex.: rates received January 20 will generally be effective no earlier than March 1). TASC cannot charge Participants for retroactive premium changes. If you fail to communicate any changes in rates before TASC's deadline, you may have to pay the premium difference to your carrier. TASC will not have any liability for any losses in premium differences due to a Plan Sponsor's failure to communicate rate changes or corrections to TASC in a timely manner.

RETIREE BILLING SET UP INFORMATION (skip for COBRA plans)

Will TASC send election packets for Retiree Billing?	☐ Yes	☐ No
Will TASC provide payment coupons for Retiree Billing?	☐ Yes	☐ No
Does client want to charge 102% for the premiums?	☐ Yes	☐ No
Does client want to charge 150% for the disability premiums?	☐ Yes	☐ No (not an option for fully insured plans in MN)

Authorized Signature_____ **Date**_____

PLAN 1 INFORMATION

Effective Date: _____ Plan Name: _____

Plan Type: ☐ Medical ☐ RX ☐ Dental ☐ Vision ☐ FSA (Healthcare Reimbursement Account) ☐ HRA ☐ EAP ☐ Life

Is this Plan bundled with another plan? ☐ No ☐ Yes, bundled with: _____

(Please record detail under Plan 2 below. Depending on the format of bundled plans, TASC may have to display bundled plan names individually on election notices.)

Is this an existing plan for which the rates and setup are not changing? ☐ Yes (no other information needs to be completed for this plan) ☐ No

Is this a new plan? ☐ No, rate change for existing plan ☐ Yes ☐ And replaces benefit plan: _____

If this is a new carrier, have you authorized carrier to work with TASC on COBRA related-issues? ☐ Yes ☐ No (If no, please do so.)

Carrier Name: _____ Group Number: _____

Boxed area needs to be completed only if carrier notifications have been arranged with TASC.

How will we notify Eligibility Contact: ☐ Email ☐ Fax

Please provide **eligibility** contact information below. ☐ Check box if carrier contact information has not changed since last renewal.

Contact Name: _____ Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact Email: _____

☐ Self-funded ☐ Fully Insured What state is the plan written in?_____

Are dependents eligible for this plan? ☐ Yes ☐ No

When does group coverage terminate after qualifying event? ☐ Event Date ☐ Month End following Event Date ☐ Other _____

Monthly Premiums – Rates should not include 2% administration fee.

For FSA plans only, what is the Plan Year End Date: _____

If rates are based on coverage tiers:

☐ Single Only _____ ☐ Single + Spouse _____

☐ Single + 1 Child _____ ☐ Single + Children _____

☐ Single + Family _____ ☐ Single + 1 Dependent _____

(If rates are age-rated or based on other composite factors, please attach table and indicate only plans that are in use.)

What date should be used to determine participant's age: ☐ Date of Birth ☐ Plan Start Date

Which date of birth should be used to determine spouse's age: ☐ Spouse DOB ☐ Participant's DOB

TASC

PLAN 2 INFORMATION

Effective Date: _____ Plan Name: _____

Plan Type: ☐ Medical ☐ RX ☐ Dental ☐ Vision ☐ FSA (Healthcare Reimbursement Account) ☐ HRA ☐ EAP ☐ Life

Is this Plan bundled with another plan? ☐ No ☐ Yes, bundled with: _____

(Please record detail in the next Plan section. Depending on the format of bundled plans, TASC may have to display bundled plan names individually on election notices.)

Is this an existing plan for which the rates and setup are not changing? ☐ Yes (no other information needs to be completed for this plan) ☐ No

Is this a new plan? ☐ No, rate change for existing plan ☐ Yes ☐ And replaces benefit plan: _____

If this is a new carrier, have you authorized carrier to work with TASC on COBRA related-issues? ☐ Yes ☐ No (If no, please do so.)

Carrier Name: _____ Group Number: _____

Boxed area needs to be completed only if carrier notifications have been arranged with TASC.

How will we notify Eligibility Contact: ☐ Email ☐ Fax

Please provide **eligibility** contact information below. ☐ Check box if carrier contact information has not changed since last renewal.

Contact Name: _____ Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact Email: _____

☐ Self-funded ☐ Fully Insured What state is the plan written in?_____

Are dependents eligible for this plan? ☐ Yes ☐ No

When does group coverage terminate after qualifying event? ☐ Event Date ☐ Month End following Event Date ☐ Other _____

Monthly Premiums – Rates should not include 2% administration fee.

For FSA plans only, what is the Plan Year End Date: _____

If rates are based on coverage tiers:

☐ Single Only _____ ☐ Single + Spouse _____

☐ Single + 1 Child _____ ☐ Single + Children _____

☐ Single + Family _____ ☐ Single + 1 Dependent _____

(If rates are age-rated or based on other composite factors, please attach table and indicate only plans that are in use.)

What date should be used to determine participant's age: ☐ Date of Birth ☐ Plan Start Date

Which date of birth should be used to determine spouse's age: ☐ Spouse DOB ☐ Participant's DOB

PLAN 3 INFORMATION

Effective Date: _____ Plan Name: _____

Plan Type: ☐ Medical ☐ RX ☐ Dental ☐ Vision ☐ FSA (Healthcare Reimbursement Account) ☐ HRA ☐ EAP ☐ Life

Is this Plan bundled with another plan? ☐ No ☐ Yes, bundled with: _____

(Please record detail in the next Plan section. Depending on the format of bundled plans, TASC may have to display bundled plan names individually on election notices.)

Is this an existing plan for which the rates and setup are not changing? ☐ Yes (no other information needs to be completed for this plan) ☐ No

Is this a new plan? ☐ No, rate change for existing plan ☐ Yes ☐ And replaces benefit plan: _____

If this is a new carrier, have you authorized carrier to work with TASC on COBRA related-issues? ☐ Yes ☐ No (If no, please do so.)

Carrier Name: _____ Group Number: _____

Boxed area needs to be completed only if carrier notifications have been arranged with TASC.

How will we notify Eligibility Contact: ☐ Email ☐ Fax

Please provide **eligibility** contact information below. ☐ Check box if carrier contact information has not changed since last renewal.

Contact Name: _____ Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact Email: _____

☐ Self-funded ☐ Fully Insured What state is the plan written in?_____

Are dependents eligible for this plan? ☐ Yes ☐ No

When does group coverage terminate after qualifying event? ☐ Event Date ☐ Month End following Event Date ☐ Other _____

Monthly Premiums – Rates should not include 2% administration fee.

For FSA plans only, what is the Plan Year End Date: _____

If rates are based on coverage tiers:

☐ Single Only _____ ☐ Single + Spouse _____

☐ Single + 1 Child _____ ☐ Single + Children _____

☐ Single + Family _____ ☐ Single + 1 Dependent _____

(If rates are age-rated or based on other composite factors, please attach table and indicate only plans that are in use.)

What date should be used to determine participant's age: ☐ Date of Birth ☐ Plan Start Date

Which date of birth should be used to determine spouse's age: ☐ Spouse DOB ☐ Participant's DOB

PLAN 4 INFORMATION

Effective Date: _____ Plan Name: _____

Plan Type: ☐ Medical ☐ RX ☐ Dental ☐ Vision ☐ FSA (Healthcare Reimbursement Account) ☐ HRA ☐ EAP ☐ Life

Is this Plan bundled with another plan? ☐ No ☐ Yes, bundled with: _____

(Please record detail in the next Plan section. Depending on the format of bundled plans, TASC may have to display bundled plan names individually on election notices.)

Is this an existing plan for which the rates and setup are not changing? ☐ Yes (no other information needs to be completed for this plan) ☐ No

Is this a new plan? ☐ No, rate change for existing plan ☐ Yes ☐ And replaces benefit plan: _____

If this is a new carrier, have you authorized carrier to work with TASC on COBRA related-issues? ☐ Yes ☐ No (If no, please do so.)

Carrier Name: _____ Group Number: _____

Boxed area needs to be completed only if carrier notifications have been arranged with TASC.

How will we notify Eligibility Contact: ☐ Email ☐ Fax

Please provide **eligibility** contact information below. ☐ Check box if carrier contact information has not changed since last renewal.

Contact Name: _____ Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact Email: _____

☐ Self-funded ☐ Fully Insured What state is the plan written in? _____

Are dependents eligible for this plan? ☐ Yes ☐ No

When does group coverage terminate after qualifying event? ☐ Event Date ☐ Month End following Event Date ☐ Other _____

Monthly Premiums – Rates should not include 2% administration fee.

For FSA plans only, what is the Plan Year End Date: _____

If rates are based on coverage tiers:

☐ Single Only _____ ☐ Single + Spouse _____

☐ Single + 1 Child _____ ☐ Single + Children _____

☐ Single + Family _____ ☐ Single + 1 Dependent _____

(If rates are age-rated or based on other composite factors, please attach table and indicate only plans that are in use.)

What date should be used to determine participant's age: ☐ Date of Birth ☐ Plan Start Date

Which date of birth should be used to determine spouse's age: ☐ Spouse DOB ☐ Participant's DOB

PLAN 5 INFORMATION

Effective Date: _____ Plan Name: _____

Plan Type: ☐ Medical ☐ RX ☐ Dental ☐ Vision ☐ FSA (Healthcare Reimbursement Account) ☐ HRA ☐ EAP ☐ Life

Is this Plan bundled with another plan? ☐ No ☐ Yes, bundled with: _____

(Please record detail in the next Plan section. Depending on the format of bundled plans, TASC may have to display bundled plan names individually on election notices.)

Is this an existing plan for which the rates and setup are not changing? ☐ Yes (no other information needs to be completed for this plan) ☐ No

Is this a new plan? ☐ No, rate change for existing plan ☐ Yes ☐ And replaces benefit plan: _____

If this is a new carrier, have you authorized carrier to work with TASC on COBRA related-issues? ☐ Yes ☐ No (If no, please do so.)

Carrier Name: _____ Group Number: _____

Boxed area needs to be completed only if carrier notifications have been arranged with TASC.

How will we notify Eligibility Contact: ☐ Email ☐ Fax

Please provide **eligibility** contact information below. ☐ Check box if carrier contact information has not changed since last renewal.

Contact Name: _____ Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact Email: _____

☐ Self-funded ☐ Fully Insured What state is the plan written in? _____

Are dependents eligible for this plan? ☐ Yes ☐ No

When does group coverage terminate after qualifying event? ☐ Event Date ☐ Month End following Event Date ☐ Other _____

Monthly Premiums – Rates should not include 2% administration fee.

For FSA plans only, what is the Plan Year End Date: _____

If rates are based on coverage tiers:

☐ Single Only _____ ☐ Single + Spouse _____

☐ Single + 1 Child _____ ☐ Single + Children _____

☐ Single + Family _____ ☐ Single + 1 Dependent _____

(If rates are age-rated or based on other composite factors, please attach table and indicate only plans that are in use.)

What date should be used to determine participant's age: ☐ Date of Birth ☐ Plan Start Date

Which date of birth should be used to determine spouse's age: ☐ Spouse DOB ☐ Participant's DOB

PLAN 6 INFORMATION

Effective Date: _____ Plan Name: _____

Plan Type: ☐ Medical ☐ RX ☐ Dental ☐ Vision ☐ FSA (Healthcare Reimbursement Account) ☐ HRA ☐ EAP ☐ Life

Is this Plan bundled with another plan? ☐ No ☐ Yes, bundled with: _____

(Please record detail in the next Plan section. Depending on the format of bundled plans, TASC may have to display bundled plan names individually on election notices.)

Is this an existing plan for which the rates and setup are not changing? ☐ Yes (no other information needs to be completed for this plan) ☐ No

Is this a new plan? ☐ No, rate change for existing plan ☐ Yes ☐ And replaces benefit plan: _____

If this is a new carrier, have you authorized carrier to work with TASC on COBRA related-issues? ☐ Yes ☐ No (If no, please do so.)

Carrier Name: _____ Group Number: _____

Boxed area needs to be completed only if carrier notifications have been arranged with TASC.

How will we notify Eligibility Contact: ☐ Email ☐ Fax

Please provide **eligibility** contact information below. ☐ Check box if carrier contact information has not changed since last renewal.

Contact Name: _____ Contact Title: _____

Contact Phone #: _____ Contact Fax #: _____ Contact Email: _____

☐ Self-funded ☐ Fully Insured What state is the plan written in? _____

Are dependents eligible for this plan? ☐ Yes ☐ No

When does group coverage terminate after qualifying event? ☐ Event Date ☐ Month End following Event Date ☐ Other _____

Monthly Premiums – Rates should not include 2% administration fee.

For FSA plans only, what is the Plan Year End Date: _____

If rates are based on coverage tiers:

☐ Single Only _____ ☐ Single + Spouse _____

☐ Single + 1 Child _____ ☐ Single + Children _____

☐ Single + Family _____ ☐ Single + 1 Dependent _____

(If rates are age-rated or based on other composite factors, please attach table and indicate only plans that are in use.)

What date should be used to determine participant's age: ☐ Date of Birth ☐ Plan Start Date

Which date of birth should be used to determine spouse's age: ☐ Spouse DOB ☐ Participant's DOB

If more plans exist, please append another form.
Please fax completed form(s) to 608-663-2753.

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