Third-Party COBRA Notification

This form is to officially notify _____ regarding a third party vendor administering group COBRA coverage.
(Insurance Carrier Name)

Carrier invoicing of a COBRA beneficiary should be a part of the employer group "active" monthly invoice and/or be made a sub-group of the employer group "active" monthly invoice. The carrier should not remit any COBRA invoicing to IntegraFlex. The employer group will remit all COBRA benenficiary monthly premium payments with its "active" employer group monthly carrier invoice.

Please fill out the following form, sign and return it to IntegraFlex with your application paperwork.

Date:
Employer Group Name:
Group Administrator Name and Contact Information:
Name of COBRA vendor:
IntegraFlex
Vendor Address:
2402 W. Jefferson Street, Boise, Idaho 83702
Vendor Contact Name:
Nena Swenson
Vendor Contact Phone Number:
(208) 562-4128
Vendor Contact E-Mail Address:
cobra@integra-flex.com
Effective Date of Business Associate Agreement with Vendor:

By completing and signing this form, the group acknowledges that it has entered into a business associate agreement with IntegraFlex, and that any information released by the insurance carrier listed above to IntegraFlex will be used and maintained in accordance with regulations set out in the Health Insurance Portability and Accountability Act (HIPAA).

Signature of authorized group representative:	
Printed name of authorized group representative:	**Date:**