Employer | COBRA Administration Set Up Form

Todays Date | COBRA Take-Over Effective Date | Tax Id No.

BUSINESS INFORMATION

Legal Company Name

DBA Name

Business Type ☐ C Corp ☐ S Corp ☐ Partnership ☐ LLC ☐ LLP ☐ Sole Proprietor **Other (Please Specify)**

MAIN CONTACT INFORMATION

Name | Title

Address | City | State | Zip

Phone | ext. | Fax | Email

PLAN INFORMATION

Current COBRA Administrator ☐ None ☐ In-House ☐ TPA

Insurance Plans to be Included ☐ Health ☐ Dental ☐ Vision ☐ HRA ☐ FSA ☐ Other

Insurance Plan Year Begins | Plan Year Ends

Self Insured ☐ No ☐ Yes; Plan(s)

COBRA Required ☐ Yes ☐ No | Number of Full-Time Employees | Part-Time Employees

First Year COBRA was required *(First calendar year employer had 20 or more Full-Time Employees – The next year was your first COBRA required Year.)*

Agent/Broker | Set Up Fee | Flat Monthly Administration Fee

Waived by TPA

Employer Signature | **Printed Name** | **Date**

Employer | Group Plan Information Request Form

I.F. IntegraFlex

MEDICAL GROUP INFORMATION - **If you do not currently receive your COBRA invoice, you will need to update this information with your carrier.**

Medical Carrier Name | Plan Year Renewal Date

Carrier Mailing Address | City | State | Zip

Carrier Contact Person, Title

Phone | Fax | Email

GROUP RATES AND INFORMATION *(Do not add the 2 percent administrative fee to the rate)*

Please list all of your health insurance group numbers with the appropriate suffix or subgroups. If there is a different group number with each group number, please specify along with the type coverage offered i.e., health, dental, vision, etc. Please give the appropriate rates that are to be billed to COBRA eligible members. (Use additional sheets if more space is needed for the group numbers.)

Group Number	Type of Coverage	Rates
	Emp.	$
	Emp.+ Spouse	$
	Emp. + Child	$
	Emp. 2+ Children	$
	Family	$

DENTAL GROUP INFORMATION - **If you do not currently receive your COBRA invoice, you will need to update this information with your carrier.**

Dental Carrier Name | Plan Year Renewal Date

Carrier Mailing Address | City | State | Zip

Carrier Contact Person, Title

Phone | Fax | Email

GROUP RATES AND INFORMATION *(Do not add the 2 percent administrative fee to the rate)*

Please list all of your health insurance group numbers with the appropriate suffix or subgroups. If there is a different group number with each group number, please specify along with the type coverage offered i.e., health, dental, vision, etc. Please give the appropriate rates that are to be billed to COBRA eligible members. (Use additional sheets if more space is needed for the group numbers.)

Group Number	Type of Coverage	Rates
	Emp.	$
	Emp.+ Spouse	$
	Emp. + Child	$
	Emp. 2+ Children	$
	Family	$

Employer | Group Plan Information Request Form Cont.

VISION GROUP INFORMATION - **If you do not currently receive your COBRA invoice, you will need to update this information with your carrier.**

Vision Carrier Name | Plan Year Renewal Date

Carrier Mailing Address | City | State | Zip

Carrier Contact Person, Title

Phone | Fax | Email

GROUP RATES AND INFORMATION *(Do not add the 2 percent administrative fee to the rate)*

Please list all of your health insurance group numbers with the appropriate suffix or subgroups. If there is a different group number with each group number, please specify along with the type coverage offered i.e., health, dental, vision, etc. Please give the appropriate rates that are to be billed to COBRA eligible members. (Use additional sheets if more space is needed for the group numbers.)

Group Number	Type of Coverage	Rates
	Emp.	$
	Emp.+ Spouse	$
	Emp. + Child	$
	Emp. 2+ Children	$
	Family	$

Employer | COBRA Administration Service Agreement

This Agreement is entered this day _____ of _____, 20 ____ between _____

(hereinafter referred to as "Employer") and Integrated Disability Management, Inc. DBA IntegraFlex an Idaho corporation (hereinafter referred to as "Service Agent"), and sets forth the basis on which Service Agent agrees to provide administrative services with respect to requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Omnibus Budget Reconciliation Act of 1987 (OBRA) for Employer. This Agreement is made in consideration of payment by Employer of the agreed-upon fee and the promises of performance by Employer and Service Agent as set forth in the Agreement.

I. PURPOSE

Service Agent shall provide certain administrative services with respect to COBRA requirements for Employer, as described in this Agreement.

II. RELATIONSHIP OF THE PARTIES

Whereas, Employer is subject to federal requirements imposed by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) to offer continuation coverage to certain people, who would otherwise lose group health care coverage; and whereas, Service Agent is willing to provide Employer with administrative services to assist Employer in meeting the requirements of COBRA. Now therefore, the parties agree as follows:

V. Service Agent shall provide current and new employees and their spouses with initial notice of the availability of continuation of coverage as required by COBRA.

VI. Employer shall notify Service Agent within 30 days of the names and current addresses of all individuals who qualify for continuation coverage. In Cases involving divorce, Employer shall take reasonable steps to ensure that the current address for the qualified beneficiaries is correct.

This Agreement between Service Agent and Employer does not create any legal relationship between the Service Agent and Employer's employees. This is an independent service agreement with Service Agent acting in the capacity of an independent contractor. There is no partnership or employer/employee relationship between Service Agent and Employer. Service Agent does not, pursuant to this Agreement, assume any responsibility for the acts, omissions or breaches of duty of Employer except for such duties as are herein expressly assumed by the Service Agent.

Service Agent shall not be deemed a fiduciary under any employee welfare benefit plan of Employer.

III. RESPONSIBILITIES OF SERVICE AGENT

Service Agent will provide the following services for Employer:

A. Notification Letters

1. Service Agent will receive from Employer a spreadsheet of employees and dependents, which are eligible for COBRA benefits. Service Agent will send a notification of the law to affected employees; separately to their insured spouses; and separately to insured dependents known to live apart from the enrolled employees, if the address is provided.
2. Upon notification by Employer to Service Agent of a qualifying event, Service Agent will, within 14 days, send a notice of COBRA rights to such identified Qualified Beneficiaries under the continuation coverage requirements, and shall provide Qualified Beneficiaries a form for election or non-election of continuation coverage.
3. Upon notification from Employer of an employee death, divorce or legal separation, or of a dependent child ceasing to be eligible for Employer's group health plan, Service Agent will send notification and election forms to the so-identified Qualified Beneficiaries as in A2 above.
4. Upon notification of Employer's filing bankruptcy under Chapter 11, Service Agent will send notification to insured retirees advising of the right to continuation of coverage (if any) under appropriate COBRA regulation.
5. If a second qualifying event occurs while a Qualified Beneficiary has elected continuation coverage (e.g., terminated employee on continuation coverage dies), and Employer notifies Service Agent of such event, or a Qualified Beneficiary notifies Service Agent. Service Agent will send notification and election forms to the Qualified Beneficiaries as in Section A2 above.
6. During the 180-day period prior to the termination of the Qualified Beneficiaries' continuation coverage period, Service Agent will notify Qualified Beneficiaries of their right to purchase a conversion health-insurance policy, if applicable, when COBRA continuation coverage ends.
7. In the event Employer provides an open enrollment period for benefit selection by employees, Qualified Beneficiaries covered under continuation coverage will be notified by Service Agent of this election option, when Employer notifies Service Agent of such open enrollment period.

B. Benefit Changes

Employer will inform Qualified Beneficiaries of any changes in Employer's benefit plan by issuing appropriate benefit plan certificates or amendments any premium changes; notification will be sent by Service Agent once the Employer has notified the Service Agent of the premium changes.

C. Customer Service

Service Agent shall provide customer service weekdays between 8:30 a.m. and 5:00 p.m. (MST), not including holidays. This service shall include answering questions about continuation coverage and the requirements of the COBRA Law.

D. COBRA Updates

Service Agent will provide Employer with periodic updates, regarding COBRA regulations when issued by the U.S. Department of Labor, U.S. Department of Treasury or the U.S. Department of Health and Human Services, all of who are responsible for issuing COBRA regulations.

E. Billing and Collection of Premium

1. Service Agent shall directly bill and collect premium from any Qualified Beneficiary who elects continuation coverage. The premium amount shall not exceed 102 percent of the applicable premium for the Employer's similarly classified employees.
2. Qualified Beneficiary's applicable initial premium shall be due within 45 Days of Service Agent's receipt of valid election form accepting continuation coverage. This applicable premium, unless modified by federal regulation, shall mean 102 percent of the premium for such determination period for similarly situated group health plan beneficiaries for whom a qualifying event has not occurred.
3. Service Agent will bill qualified Beneficiaries and remit premium payments directly to the Employer.

IV. RESPONSIBILITIES OF EMPLOYER

A. Employer remains Plan Administrator and Plan Fiduciary, Employer delegates to Service Agent certain administrative duties associated with continuation coverage as set forth in Section III.

B. Employer shall notify Service Agent via the Employer secure web site verifying the following information when a Qualifying Event occurs:

1. Name and address of Qualified Beneficiaries
2. Type of Qualifying Event and type of Health Coverage of the Member(s)
3. Date of Qualifying Event
4. Contract type of the member (I.e., single coverage, two-person, etc.)

V. INDEMNIFICATION

Employer agrees to indemnify Service Agent and to hold Service Agent fully protected and harmless for all damages and causes of action of whatsoever kind, including attorneys' fees, costs of defense and penalties of all variety occasioned by Service Agent's undertaking of this Agreement.

Employer | COBRA Administration Service Agreement

I.F. IntegraFlex

FEES AND PAYMENT

Around the 1st of each month Service Agent will submit a statement to Employer showing Service Agent fees for service during that month. Employer agrees to pay such fees through ACH Debit on the 10th of each month or the next available business day following the 10th. Employer hereby authorizes (refer to "ACH Debit Authorization Form") and requests Service Agent to effect payment for any amounts owing by Employer to Service Agent as such amounts become due by initiating debit entries to Employer's bank account as identified.

The below listed fee schedule will apply for the benefit plan:

This benefit plan will start on _____

One Time Set Up Fee $ **Waived by TPA**

Annual Renewal Fee $ **150.00**

Per Employee per Month (pepm) $ **N/A**

Flat Monthly Fee $ _____

TERMS OF AGREEMENT

The terms of this Agreement shall begin on the date stated on page 1, paragraph 1, and shall continue for at least one year and thereafter until terminated by either Employer or Service Agent upon 60-days written notice. IN WITNESS WHEREOF, Employer and Service Agent have manifested their undertaking and intent to be legally bound by the signatures of their legally authorized representatives below.

INTEGRAFLEX

Keith S. Paduch
By

CEO
Its

Signature

Date

CLIENT

By

Its

Signature

Date

Employer | ACH Debit Authorization Form

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS) FOR MONTHLY ADMINISTRATION FEES

Bank Filter Information: **Company Name:** INTEGRAFLEX
Company ID Number: 1-260404651
Description: Admin. Fees

I (we) hereby authorize Integrated Disability Management, Inc. d/b/a/ IntegraFlex hereinafter called COMPANY, to initiate debit entries to my (our) *(select one)*

☐ **Checking Account**

☐ **Savings Account**

indicated below at the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

DEPOSITORY INFORMATION

Depository Name | Branch

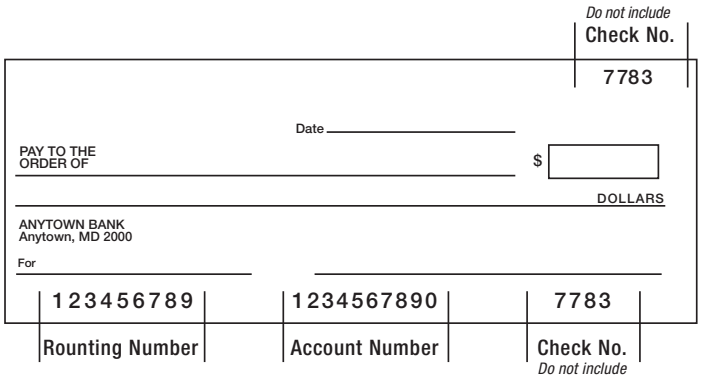
Address | City | State | Zip

Routing Number *(9 Digits)* | Account Number

This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Name(s) *(Please Print)*

Signature **Date**



Please attach a **VOIDED CHECK** to this authorization if a checking account will be debited.
The routing and account numbers may be in different places on your check.