

Employer | Group Plan Information Request Form



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	\$