COBRA Premium Collection Form

For fastest processing, submit this form and any coverage documents online via support request. You may also use one of the following methods:	Fax	Mail
	608-245-3623	BASIC, PO Box 14015 Madison, WI 53708-0015

CLIENT/EMPLOYER INFORMATION

Client/Employer Name:		Employer ID (12-digit):	
Division:[1]		Employee Count:[2]	
Client/Employer Email:		Client/Employer Phone:	

1. If you have multiple branches, subsidiaries or locations and offer different plans for each, complete a separate form for each group.
2. Provide count of employees to determine if COBRA Small Employer Exception applies. Prorate all part-time employees and give total count.

RETIREE BILLING SETUP

Do not complete this section for COBRA plans.

Will BASIC send election packets for Retiree Billing?	☐ Yes ☐ No
Will Client/Employer charge 102% for premiums?	☐ Yes ☐ No
Will Client/Employer charge 150% for disability premiums?	☐ Yes ☐ No *(not an option for fully insured plans in MN)*

PLAN 1 INFORMATION

Plan Name:				Effective Date:	
Plan Type:	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP ☐ FSA ☐ HRA				
Plan Setup:	☐ Self-Funded ☐ Fully Insured			*(FSA Plans Only)* Plan Year End Date:	
What state is the plan written in?			Are dependents eligible for this plan?	☐ Yes ☐ No	
When does group coverage terminate?	☐ QE Date ☐ Month End After QE Date ☐ Other:				
Is this plan bundled with another plan?	☐ No ☐ Yes, bundled with:				
Record detail in the next section. Depending on format, bundled plan names may be displayed individually on election notices.					
Is this an existing plan for which rates and setup are not changing?	☐ Yes *(no other plan information needed)* ☐ No				
Is this a new plan?	☐ No, rate change for existing ☐ Yes ☐ And replaces:				
Monthly Premium Rates: *(Do not include 2% administration fee.)*					
If age rated: *(Attach table; only indicate plans in use.)*	Date used to determine participant's age:	☐ Date of Birth ☐ Plan Start Date			
	Date used to determine spouse's age:	☐ Spouse DOB ☐ Participant's DOB			
If based on coverage tiers:	Single	Single + Spouse	Single + 1 Child	Single + Children	Single + Family
Carrier Name:				Group Number:	
Is this a new carrier?	☐ Yes ☐ No	BASIC performing Carrier Notifications?	☐ No ☐ Yes *(Complete fields below.)*		
Eligibility Contact Name:				Contact Title:	
Contact Phone:		Contact Fax:		Contact Email:	
How will BASIC notify Contact?	☐ Fax ☐ Email	Has contact info changed since last renewal?	☐ Yes ☐ No		

Authorization Signature Required on Last Page

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PLAN 2 INFORMATION

Plan Name:		Effective Date:	
Plan Type:	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP ☐ FSA ☐ HRA		
Plan Setup:	☐ Self-Funded ☐ Fully Insured	*(FSA Plans Only)* Plan Year End Date:	
What state is the plan written in?		Are dependents eligible for this plan?	☐ Yes ☐ No
When does group coverage terminate?	☐ QE Date ☐ Month End After QE Date ☐ Other:		
Is this plan bundled with another plan?	☐ No ☐ Yes, bundled with:		
Is this an existing plan for which rates and setup are not changing?	☐ Yes *(no other plan information needed)* ☐ No		
Is this a new plan?	☐ No, rate change for existing ☐ Yes ☐ And replaces:		

Monthly Premium Rates: *(Do not include 2% administration fee.)*

If age rated: *(Attach table; only indicate plans in use.)*	Date used to determine participant's age:	☐ Date of Birth ☐ Plan Start Date
	Date used to determine spouse's age:	☐ Spouse DOB ☐ Participant's DOB

If based on coverage tiers:	Single	Single + Spouse	Single + 1 Child	Single + Children	Single + Family

Carrier Name:		Group Number:	
Is this a new carrier?	☐ Yes ☐ No	BASIC performing Carrier Notifications?	☐ No ☐ Yes *(Complete fields below.)*
Eligibility Contact Name:		Contact Title:	
Contact Phone:	Contact Fax:	Contact Email:	
How will BASIC notify Contact?	☐ Fax ☐ Email	Has contact info changed since last renewal?	☐ Yes ☐ No

PLAN 3 INFORMATION

Plan Name:		Effective Date:	
Plan Type:	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP ☐ FSA ☐ HRA		
Plan Setup:	☐ Self-Funded ☐ Fully Insured	*(FSA Plans Only)* Plan Year End Date:	
What state is the plan written in?		Are dependents eligible for this plan?	☐ Yes ☐ No
When does group coverage terminate?	☐ QE Date ☐ Month End After QE Date ☐ Other:		
Is this plan bundled with another plan?	☐ No ☐ Yes, bundled with:		
Is this an existing plan for which rates and setup are not changing?	☐ Yes *(no other plan information needed)* ☐ No		
Is this a new plan?	☐ No, rate change for existing ☐ Yes ☐ And replaces:		

Monthly Premium Rates: *(Do not include 2% administration fee.)*

If age rated: *(Attach table; only indicate plans in use.)*	Date used to determine participant's age:	☐ Date of Birth ☐ Plan Start Date
	Date used to determine spouse's age:	☐ Spouse DOB ☐ Participant's DOB

If based on coverage tiers:	Single	Single + Spouse	Single + 1 Child	Single + Children	Single + Family

Carrier Name:		Group Number:	
Is this a new carrier?	☐ Yes ☐ No	BASIC performing Carrier Notifications?	☐ No ☐ Yes *(Complete fields below.)*
Eligibility Contact Name:		Contact Title:	
Contact Phone:	Contact Fax:	Contact Email:	
How will BASIC notify Contact?	☐ Fax ☐ Email	Has contact info changed since last renewal?	☐ Yes ☐ No

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PLAN 4 INFORMATION

Plan Name:		Effective Date:	
Plan Type:	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP ☐ FSA ☐ HRA		
Plan Setup:	☐ Self-Funded ☐ Fully Insured	*(FSA Plans Only)* Plan Year End Date:	
What state is the plan written in?		Are dependents eligible for this plan?	☐ Yes ☐ No
When does group coverage terminate?	☐ QE Date ☐ Month End After QE Date ☐ Other:		
Is this plan bundled with another plan?	☐ No ☐ Yes, bundled with:		
Is this an existing plan for which rates and setup are not changing?	☐ Yes *(no other plan information needed)* ☐ No		
Is this a new plan?	☐ No, rate change for existing ☐ Yes ☐ And replaces:		

Monthly Premium Rates: *(Do not include 2% administration fee.)*					
If age rated: *(Attach table; only indicate plans in use.)*	Date used to determine participant's age:	☐ Date of Birth ☐ Plan Start Date			
	Date used to determine spouse's age:	☐ Spouse DOB ☐ Participant's DOB			
If based on coverage tiers:	Single	Single + Spouse	Single + 1 Child	Single + Children	Single + Family

Carrier Name:		Group Number:	
Is this a new carrier?	☐ Yes ☐ No	BASIC performing Carrier Notifications?	☐ No ☐ Yes *(Complete fields below.)*
Eligibility Contact Name:		Contact Title:	
Contact Phone:	Contact Fax:	Contact Email:	
How will BASIC notify Contact?	☐ Fax ☐ Email	Has contact info changed since last renewal?	☐ Yes ☐ No

PLAN 5 INFORMATION

Plan Name:		Effective Date:	
Plan Type:	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP ☐ FSA ☐ HRA		
Plan Setup:	☐ Self-Funded ☐ Fully Insured	*(FSA Plans Only)* Plan Year End Date:	
What state is the plan written in?		Are dependents eligible for this plan?	☐ Yes ☐ No
When does group coverage terminate?	☐ QE Date ☐ Month End After QE Date ☐ Other:		
Is this plan bundled with another plan?	☐ No ☐ Yes, bundled with:		
Is this an existing plan for which rates and setup are not changing?	☐ Yes *(no other plan information needed)* ☐ No		
Is this a new plan?	☐ No, rate change for existing ☐ Yes ☐ And replaces:		

Monthly Premium Rates: *(Do not include 2% administration fee.)*					
If age rated: *(Attach table; only indicate plans in use.)*	Date used to determine participant's age:	☐ Date of Birth ☐ Plan Start Date			
	Date used to determine spouse's age:	☐ Spouse DOB ☐ Participant's DOB			
If based on coverage tiers:	Single	Single + Spouse	Single + 1 Child	Single + Children	Single + Family

Carrier Name:		Group Number:	
Is this a new carrier?	☐ Yes ☐ No	BASIC performing Carrier Notifications?	☐ No ☐ Yes *(Complete fields below.)*
Eligibility Contact Name:		Contact Title:	
Contact Phone:	Contact Fax:	Contact Email:	
How will BASIC notify Contact?	☐ Fax ☐ Email	Has contact info changed since last renewal?	☐ Yes ☐ No

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PLAN 6 INFORMATION

Plan Name:		Effective Date:	
Plan Type:	☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Life ☐ EAP ☐ FSA ☐ HRA		
Plan Setup:	☐ Self-Funded ☐ Fully Insured	*(FSA Plans Only)* Plan Year End Date:	
What state is the plan written in?		Are dependents eligible for this plan?	☐ Yes ☐ No
When does group coverage terminate?	☐ QE Date ☐ Month End After QE Date ☐ Other:		
Is this plan bundled with another plan?	☐ No ☐ Yes, bundled with:		
Is this an existing plan for which rates and setup are not changing?	☐ Yes *(no other plan information needed)* ☐ No		
Is this a new plan?	☐ No, rate change for existing ☐ Yes ☐ And replaces:		

Monthly Premium Rates: *(Do not include 2% administration fee.)*

If age rated: *(Attach table; only indicate plans in use.)*	Date used to determine participant's age:	☐ Date of Birth ☐ Plan Start Date
	Date used to determine spouse's age:	☐ Spouse DOB ☐ Participant's DOB

If based on coverage tiers:	Single	Single + Spouse	Single + 1 Child	Single + Children	Single + Family

Carrier Name:		Group Number:	
Is this a new carrier?	☐ Yes ☐ No	BASIC performing Carrier Notifications?	☐ No ☐ Yes *(Complete fields below.)*
Eligibility Contact Name:		Contact Title:	
Contact Phone:	Contact Fax:	Contact Email:	
How will BASIC notify Contact?	☐ Fax ☐ Email	Has contact info changed since last renewal?	☐ Yes ☐ No

If more plans exist, please append another form.

ACKNOWLEDGMENT

PLEASE NOTE: To maintain compliance with federal law, BASIC requires that any changes in rates be submitted 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 until at least the first of the month following the month for which rates were received (e.g., rates received January 20 will generally be effective no earlier than March 1). BASIC cannot charge participants for retroactive premium changes. If you fail to communicate any changes in rates before BASIC's deadline, you may have to pay the premium difference to your carrier. BASIC 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 BASIC in a timely manner.

______________________________ ______________

Print Name **Title**

______________________________ ______________

Signature **Date**

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