



# 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:	<b>Fax</b>	<b>Mail</b>
	608-245-3623	TASC, PO Box 14015 Madison, WI 53708-0015

## CLIENT/EMPLOYER INFORMATION

Client/Employer Name:		TASC ID (12-digit):	
Division: <sup>1</sup>		Employee Count: <sup>2</sup>	
Client/Employer Email:		Client/Employer Phone:	

- If you have multiple branches, subsidiaries or locations and offer different plans for each, complete a separate form for each group.
- 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 TASC send election packets for Retiree Billing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will Client/Employer charge 102% for premiums?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will Client/Employer charge 150% for disability premiums?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>(not an option for fully insured plans in MN)</i>

## PLAN 1 INFORMATION

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

**\*\*Authorization Signature Required on Last Page\*\***



# COBRA Premium Collection Form

## PLAN 2 INFORMATION

Plan Name:					Effective Date:		
Plan Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Prescription	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life	<input type="checkbox"/> EAP	<input type="checkbox"/> FSA <input type="checkbox"/> HRA
Plan Setup:	<input type="checkbox"/> Self-Funded	<input type="checkbox"/> Fully Insured	(FSA Plans Only) Plan Year End Date:				
What state is the plan written in?				Are dependents eligible for this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
When does group coverage terminate?	<input type="checkbox"/> QE Date <input type="checkbox"/> Month End After QE Date <input type="checkbox"/> Other:						
Is this plan bundled with another plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes, bundled with:						
Is this an existing plan for which rates and setup are not changing?	<input type="checkbox"/> Yes (no other plan information needed) <input type="checkbox"/> No						
Is this a new plan?	<input type="checkbox"/> No, rate change for existing <input type="checkbox"/> Yes <input type="checkbox"/> And replaces:						
<b>Monthly Premium Rates:</b> (Do not include 2% administration fee.)							
If age rated: (Attach table; only indicate plans in use.)	Date used to determine participant's age:			<input type="checkbox"/> Date of Birth <input type="checkbox"/> Plan Start Date			
	Date used to determine spouse's age:			<input type="checkbox"/> Spouse DOB <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TASC performing Carrier Notifications?		<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete fields below.)			
Eligibility Contact Name:					Contact Title:		
Contact Phone:			Contact Fax:			Contact Email:	
How will TASC notify Contact?	<input type="checkbox"/> Fax <input type="checkbox"/> Email		Has contact info changed since last renewal?			<input type="checkbox"/> Yes <input type="checkbox"/> No	

## PLAN 3 INFORMATION

Plan Name:					Effective Date:		
Plan Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Prescription	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life	<input type="checkbox"/> EAP	<input type="checkbox"/> FSA <input type="checkbox"/> HRA
Plan Setup:	<input type="checkbox"/> Self-Funded	<input type="checkbox"/> Fully Insured	(FSA Plans Only) Plan Year End Date:				
What state is the plan written in?				Are dependents eligible for this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
When does group coverage terminate?	<input type="checkbox"/> QE Date <input type="checkbox"/> Month End After QE Date <input type="checkbox"/> Other:						
Is this plan bundled with another plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes, bundled with:						
Is this an existing plan for which rates and setup are not changing?	<input type="checkbox"/> Yes (no other plan information needed) <input type="checkbox"/> No						
Is this a new plan?	<input type="checkbox"/> No, rate change for existing <input type="checkbox"/> Yes <input type="checkbox"/> And replaces:						
<b>Monthly Premium Rates:</b> (Do not include 2% administration fee.)							
If age rated: (Attach table; only indicate plans in use.)	Date used to determine participant's age:			<input type="checkbox"/> Date of Birth <input type="checkbox"/> Plan Start Date			
	Date used to determine spouse's age:			<input type="checkbox"/> Spouse DOB <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TASC performing Carrier Notifications?		<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete fields below.)			
Eligibility Contact Name:					Contact Title:		
Contact Phone:			Contact Fax:			Contact Email:	
How will TASC notify Contact?	<input type="checkbox"/> Fax <input type="checkbox"/> Email		Has contact info changed since last renewal?			<input type="checkbox"/> Yes <input type="checkbox"/> No	



# COBRA Premium Collection Form

## PLAN 4 INFORMATION

Plan Name:					Effective Date:		
Plan Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Prescription	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life	<input type="checkbox"/> EAP	<input type="checkbox"/> FSA <input type="checkbox"/> HRA
Plan Setup:	<input type="checkbox"/> Self-Funded	<input type="checkbox"/> Fully Insured	(FSA Plans Only) Plan Year End Date:				
What state is the plan written in?				Are dependents eligible for this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
When does group coverage terminate?	<input type="checkbox"/> QE Date <input type="checkbox"/> Month End After QE Date <input type="checkbox"/> Other:						
Is this plan bundled with another plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes, bundled with:						
Is this an existing plan for which rates and setup are not changing?	<input type="checkbox"/> Yes (no other plan information needed) <input type="checkbox"/> No						
Is this a new plan?	<input type="checkbox"/> No, rate change for existing <input type="checkbox"/> Yes <input type="checkbox"/> And replaces:						
<b>Monthly Premium Rates:</b> (Do not include 2% administration fee.)							
If age rated: (Attach table; only indicate plans in use.)	Date used to determine participant's age:			<input type="checkbox"/> Date of Birth <input type="checkbox"/> Plan Start Date			
	Date used to determine spouse's age:			<input type="checkbox"/> Spouse DOB <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TASC performing Carrier Notifications?		<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete fields below.)			
Eligibility Contact Name:					Contact Title:		
Contact Phone:			Contact Fax:			Contact Email:	
How will TASC notify Contact?	<input type="checkbox"/> Fax	<input type="checkbox"/> Email	Has contact info changed since last renewal?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

## PLAN 5 INFORMATION

Plan Name:					Effective Date:		
Plan Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Prescription	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life	<input type="checkbox"/> EAP	<input type="checkbox"/> FSA <input type="checkbox"/> HRA
Plan Setup:	<input type="checkbox"/> Self-Funded	<input type="checkbox"/> Fully Insured	(FSA Plans Only) Plan Year End Date:				
What state is the plan written in?				Are dependents eligible for this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
When does group coverage terminate?	<input type="checkbox"/> QE Date <input type="checkbox"/> Month End After QE Date <input type="checkbox"/> Other:						
Is this plan bundled with another plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes, bundled with:						
Is this an existing plan for which rates and setup are not changing?	<input type="checkbox"/> Yes (no other plan information needed) <input type="checkbox"/> No						
Is this a new plan?	<input type="checkbox"/> No, rate change for existing <input type="checkbox"/> Yes <input type="checkbox"/> And replaces:						
<b>Monthly Premium Rates:</b> (Do not include 2% administration fee.)							
If age rated: (Attach table; only indicate plans in use.)	Date used to determine participant's age:			<input type="checkbox"/> Date of Birth <input type="checkbox"/> Plan Start Date			
	Date used to determine spouse's age:			<input type="checkbox"/> Spouse DOB <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	TASC performing Carrier Notifications?		<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete fields below.)			
Eligibility Contact Name:					Contact Title:		
Contact Phone:			Contact Fax:			Contact Email:	
How will TASC notify Contact?	<input type="checkbox"/> Fax	<input type="checkbox"/> Email	Has contact info changed since last renewal?		<input type="checkbox"/> Yes <input type="checkbox"/> No		



# COBRA Premium Collection Form

## PLAN 6 INFORMATION

Plan Name:					Effective Date:		
Plan Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Prescription	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Life	<input type="checkbox"/> EAP	<input type="checkbox"/> FSA <input type="checkbox"/> HRA
Plan Setup:	<input type="checkbox"/> Self-Funded <input type="checkbox"/> Fully Insured		(FSA Plans Only) Plan Year End Date:				
What state is the plan written in?				Are dependents eligible for this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
When does group coverage terminate?	<input type="checkbox"/> QE Date <input type="checkbox"/> Month End After QE Date <input type="checkbox"/> Other:						
Is this plan bundled with another plan?	<input type="checkbox"/> No <input type="checkbox"/> Yes, bundled with:						
Is this an existing plan for which rates and setup are not changing?	<input type="checkbox"/> Yes (no other plan information needed) <input type="checkbox"/> No						
Is this a new plan?	<input type="checkbox"/> No, rate change for existing <input type="checkbox"/> Yes <input type="checkbox"/> And replaces:						
<b>Monthly Premium Rates:</b> (Do not include 2% administration fee.)							
If age rated: (Attach table; only indicate plans in use.)	Date used to determine participant's age:			<input type="checkbox"/> Date of Birth <input type="checkbox"/> Plan Start Date			
	Date used to determine spouse's age:			<input type="checkbox"/> Spouse DOB <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No		TASC performing Carrier Notifications?	<input type="checkbox"/> No <input type="checkbox"/> Yes (Complete fields below.)			
Eligibility Contact Name:					Contact Title:		
Contact Phone:			Contact Fax:			Contact Email:	
How will TASC notify Contact?	<input type="checkbox"/> Fax <input type="checkbox"/> Email		Has contact info changed since last renewal?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

If more plans exist, please append another form.

## ACKNOWLEDGMENT

**PLEASE NOTE:** To maintain compliance with federal law, TASC 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). 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.

Print Name

Title

Signature

Date

TASC | 2302 International Lane | Madison, WI 53704-3140 | 800-422-4661 | www.tasconline.com | CO-0007-041823

The information contained in this document is confidential and to be used by TASC employees and representatives for only its intended purpose.

Copyright © 2023 Total Administrative Services Corporation. All rights reserved.