COBRAToday®

Premium Collection Form

EMPLOYER NAME: Grand Rapids BRANCH: ______

CLIENT ID: 4601-8353-6645 ,BS04 & BS04R

If you have multiple branches, subsidiaries, or locations and offer different benefit plans/premiums for each, please complete a separate form for each group.

PLEASE NOTE: ***To maintain compliance with federal law,*** COBRAToday requires that any changes in rates must be submitted to COBRAToday at least 15 days before 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 within 15 days of the effective date, implementation will be delayed until the first of the month following the month in which the rates were received. **Under federal law, COBRAToday cannot charge Participants retroactive premium changes.** If you fail to communicate any changes in rates before COBRAToday's deadline, you may have to pay the premium difference to your carrier. COBRAToday will not have any liability for any losses in premium differences due to a Plan Sponsor's failure to communicate rate changes or corrections in a timely manner.

EFFECTIVE DATE: From 1/1/2024 Through 12/31/2025 (Use separate form for different effective dates.)

BENEFIT PLAN INFORMATION: Please supply the exact carrier rates. COBRAToday will add the 2% administration fee if applicable. If Plans are age-rated, attach age-rated tables as provided by the carrier. The carrier information requested below is for informational purposes only. COBRAToday will not notify carriers directly of any COBRA changes unless contracted to do so through our Premium Services Department.

Coverage Type	Plan Name	Employee Only	Employee + Spouse	Employee + 1 Child	Employee + Family	Employee + Children
Medical (Opt 1):		$	$	$	$	$

Is this Plan Self-Funded? ☐ No ☐ Yes

Does this Plan replace a former Plan? ☐ No ☐ Yes Name of former Plan: ______

COBRA Period Begins: ☐ First of the month following qualifying event ☐ Day after qualifying event ☐ Other (please specify): ______

Insurance Carrier Name: ______ Carrier Address: ______

Coverage Type	Plan Name	Employee Only	Employee + Spouse	Employee + 1 Child	Employee + Family	Employee + Children
Medical (Opt 2):		$	$	$	$	$

Is this Plan Self-Funded? ☐ No ☐ Yes

Does this Plan replace a former Plan? ☐ No ☐ Yes Name of former Plan: ______

COBRA Period Begins: ☐ First of the month following qualifying event ☐ Day after qualifying event ☐ Other (please specify): ______

Insurance Carrier Name: ______ Carrier Address: ______

Coverage Type	Plan Name	Employee Only	Employee + Spouse	Employee + 1 Child	Employee + Family	Employee + Children
Medical (Opt 3):		$	$	$	$	$

Is this Plan Self-Funded? ☐ No ☐ Yes

Does this Plan replace a former Plan? ☐ No ☐ Yes Name of former Plan: ______

COBRA Period Begins: ☐ First of the month following qualifying event ☐ Day after qualifying event ☐ Other (please specify): ______

Insurance Carrier Name: ______ Carrier Address: ______

Coverage Type	Plan Name	Employee Only	Employee + Spouse	Employee + 1 Child	Employee + Family	Employee + Children
Dental:		$	$	$	$	$

Is this Plan Self-Funded? ☐ No ☐ Yes

Does this Plan replace a former Plan? ☐ No ☐ Yes Name of former Plan: ______

COBRA Period Begins: ☐ First of the month following qualifying event ☐ Day after qualifying event ☐ Other (please specify): ______

Insurance Carrier Name: ______ Carrier Address: ______

Coverage Type	Plan Name	Employee Only	Employee + Spouse	Employee + 1 Child	Employee + Family	Employee + Children
Vision:	Avesis Vision material only base plan	$6.90	$13.04	$14.21	$18.30	$14.21

Is this Plan Self-Funded? ■ No ☐ Y

Does this Plan replace a former Plan? ☐ No ■ Yes Name of former Plan: Avesis Vis - COBRA & RETIREE

COBRA Period Begins: ■ First of the month following qualifying event ☐ Day after qualifying event ☐ Other (please specify): ______

Insurance Carrier Name: ______ Carrier Address: ______

Coverage Type	Plan Name	Employee Only	Employee + Spouse	Employee + 1 Child	Employee + Family	Employee + Children
HRA:		$	$	$	$	$
Other:		$	$	$	$	$

FSA Plan Year End Date: ______ Annual Maximum: $______

★ Authorized Signature: ______ Date: ______

Please fax completed form(s) to 608-663-2753.

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