COBRA Administration New Client Forms

for Presbyterian Groups
(Updated 2016)

Two (2) pages are needed if a group has only Presbyterian plan(s) that they wish to have CONEXIS administer for COBRA:

1. Presbyterian New Client Notification (condensed into one page)

2. Administrative Services Agreement Fee Appendix to be completed and signed by Presbyterian representative

If a group has additional, non-Presbyterian plans, there will be 2 additional pages needed:

3. Carrier and Plan Information for Non-Presbyterian Plans

4. Administrative Services Agreement Fee Appendix for Additional Plan Options, fees to be paid by Client, to be completed and signed by client.

COMPLETED NEW CLIENT PAPERWORK SHOULD BE EMAILED TO:

cxdnewbusiness@conexis.com
jraymond@conexis.com

Also enclosed is a form for the Client to use when they renew to provide CONEXIS with their rate changes.

1. Plan and Rate Change form – should be emailed to CXDRates@conexis.com

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Please return to cxdnewbusiness@conexis.com

Presbyterian New Client Notification

Employer Name: _____ Desired Effective Date _____

Address: _____ City: _____ St: _____ Zip: _____

FEIN: _____ Nature of Business: _____

CONTACT INFORMATION:

Contact Type	Contact Name	Title	Phone	Fax	E-mail	Web Access	Monthly Invoice	HIPAA Authorized*
Executive			( ) -	( ) -		☐Read Only ☐ Update ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Admin*			( ) -	( ) -		☐Read Only ☐ Update ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Broker			( ) -	( ) -		☐Read Only ☐ Update ☐ No	N/A	☐ Yes ☐ No
Carrier Field Rep			( ) -	( ) -		N/A	N/A	☐ Yes ☐ No

***Unless otherwise specified, this contact will be our primary contact.**
***HIPAA Authorized- there must be at least "one" HIPAA Authorized contact with web access.**

Please indicate which contact above is the recipient of the monthly COBRA premium payment _____
Number of Fulltime Employees: _____
Number of Employees covered on a COBRA eligible Plan: _____
Number of Current COBRA continuants: _____
Disability surcharge: 102% 150%

GENERAL INFORMATION

Cost to Continue Coverage(s) – Rates must be provided for ALL options listed below (COBRA regulation)

Group / Policy #: _____ **Carrier & Plan Name #1** _____

100% of Premium Charged by Plan Carrier **(Do not include 2%)**	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family (EE,SP & Child(ren)**	**Spouse Only**	**Spouse + Child(ren)**	**Child Only**	**Children Only**
	$	$	$	$	$	$	$	$

Effective date of these rates: _____ Anniversary date of this plan: _____
Is there a waiting period? ☐Yes ☐No If yes, how long _____ ☐Days ☐ Months ☐ Other _____
Plan is effective: ☐ same day ☐ next day ☐ first of the month following the waiting period
When does coverage end for terminations? ☐ Date of Termination ☐ End of Month
☐Next Day after Termination ☐15th of Month ☐Other _____
Dependent children age limit: _____ Full-time student age limit: _____

Group / Policy #: _____ **Carrier & Plan Name #2** _____
Cost to Continue Coverage(s) – Rates must be provided for ALL options listed below (COBRA regulation)

100% of Premium Charged by Plan Carrier **(Do not include 2%)**	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family (EE,SP & Child(ren)**	**Spouse Only**	**Spouse + Child(ren)**	**Child Only**	**Children Only**
	$	$	$	$	$	$	$	$

Effective date of these rates: _____ Anniversary date of this plan: _____
Is there a waiting period? ☐Yes ☐No If yes, how long _____ ☐Days ☐ Months ☐ Other _____
Plan is effective: ☐ same day ☐ next day ☐ first of the month following the waiting period

When does coverage end for terminations? ☐ Date of Termination ☐ End of Month
☐Next Day after Termination ☐15th of Month ☐Other _____

Dependent children age limit: _____ Full-time student age limit: _____

Prepared by: _____ Signature: _____ Date: _____

CONEXIS-ADMINISTRATIVE SERVICES AGREEMENT
FEE APPENDIX – Schedule of Service Fees

Fees to be paid by: **Presbyterian Health Plan CID: CXD14938**

For Client: _____

This Fee Appendix – Schedule of Service Fees is incorporated into and made a part of the Service Agreement ("Agreement"). If there is a conflict between this Fee Appendix and the Agreement, the Agreement controls. This Schedule represents the services and fees agreed between **Presbyterian Health Plan** and **CONEXIS a division of WageWorks, Inc. ("CONEXIS") t**o be offered to the clients of **Presbyterian Health Plan.**

CONEXIS SERVICES FEES

Item Code	Description	2016 Fee
	Any services marked as $0.00 are included in Base Fee	
	Administrative Fees	
C8090	COBRA Implementation / Set up Fee (One Time New Client)	**$ 100.00**
	Per Employee Per Month Fee (PEPM) Base Fee	
C0915	COBRA Administration — Covered Employee (Client provided)	**$ 0.56**
	COBRA Administration Services	
C5752	COBRA Notice and Plan Alternatives	**$ 0.00**
C5850	COBRA General Notice	**$ 0.00**
C3759	COBRA Expiration Notice	$ 0.00
C6303	COBRA Takeover Continuant Fee	$ 0.00
C446D	Monthly COBRA Invoice	$ 0.00
C2587	Carrier Eligibility	$ 0.00

CONEXIS Open Enrollment Services
Contact Client Services to utilize CONEXIS **COBRA Open Enrollment Services**
Services and pricing will be determined each year based on requested services

Service Fee Guarantee Period: January 1, 2016 through December 31, 2016

PHP Authorized Signature: _____ **Date:** _____

Name and Title: _____

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Carrier and Plan Information for Non-Presbyterian Plans of Presbyterian Clients

Instructions: Complete form for each employer-sponsored group health plan subject to COBRA. Use a separate form for each non-Presbyterian plan with a unique set of rates and/or group number. **A Fee Appendix for "CLIENT ADDITIONAL PLAN OPTIONS"** must accompany this form. Return these forms with the completed Presbyterian New Client Notification.

Section A-Plan Information for non-Presbyterian Plan

Employer Name	Carrier Name:

Group/Policy Number	Dependent Children Age Limit	Full-Time Student Age Limit

Plan Effective Date:	Plan Renewal Date	Is there a Waiting Period	If yes, how long?	Following the waiting period, coverage is effective
		☐ Yes ☐ No	☐ Days ☐ Months	☐ Immediately ☐ Next Day ☐ First of the Month

Coverage ceases

☐ Date of termination ☐ End of month ☐ Next Day after Termination ☐ 15th of the Month ☐ Other

Plan Name	Is this plan 'bundled' together with other plans (participants are required to elect all plans to continue coverage)? If yes, list plan names

Plan Type (Mark all boxes that apply)

☐ Medical ☐ Dental ☐ Vision ☐ Rx ☐ Medical FSA ☐ Self Funded ☐ Fully Insured ☐ HMO ☐ PPO ☐ POS ☐ Indemnity

Section B-Carrier Eligibility Contact – Complete if you want eligibility reported directly to the carrier.

Eligibility Contact Name	Customer Service Toll Free Number

Address

City	State	Zip

Telephone Number	**FAX Number**	E-mail

Section C-Rates

Rates (if 10-tier structure) **Do not include the 2% COBRA Administrative Fee**

Employee	**Employee + Spouse**	**Employee + Child(ren)**	**Spouse Only**	**Spouse + Child(ren)**	**Children Only**	**Child Only**	**Family**

Rates (if 3-tier structure) **Do not include the 2% COBRA Administrative Fee**

Individual Only	**Individual + 1**	**Individual + 2 or more**

Section D-Employer Representative-Form completed by:

Name	Title	Phone Number

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CONEXIS-ADMINISTRATIVE SERVICES AGREEMENT
FEE APPENDIX – Schedule of Service Fees

CLIENT ADDITIONAL PLAN OPTIONS

Fees Billed To Client: _____

This Fee Appendix – Schedule of Service Fees is incorporated into and made a part of the Service Agreement ("Agreement"). If there is a conflict between this Fee Appendix and the Agreement, the Agreement controls. This Schedule represents the additional COBRA administration of non **Presbyterian** plans by **CONEXIS a division of WageWorks, Inc. ("CONEXIS") for the client's of Presbyterian Health Plan.**

Fees will be paid by the Client of Presbyterian Health Plan. There is a flat monthly fee of $20.00 for COBRA Administration and Client/Carrier eligibilty reporting regardless of the number of plans.

Client Name: _____

Item Code	Description	2016 Fee
	Any services marked as $0.00 are included in Base Fee	
	Administrative Fees	
C2791	**Monthly Administration Fee)**	**$20.00**
	Reporting Fees	
C2587	**Carrier Eligibility Reporting Fee)**	$.00

Service Period: _____

Authorized Bill To Signature: _____ **Date:** _____

Name and Title: _____

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Plan and Rate Change Form

Instructions:

PLEASE NOTE THAT IT IS THE CLIENT'S RESPONSIBILITY TO PROVIDE UPDATED PLAN AND RATE INFORMATION TO CONEXIS WHEN YOU HAVE ANY CHANGES.

Complete the form for each current employer-sponsored group health plan subject to COBRA.
Use a separate form for each plan and return to CXDRates@CONEXIS.com or fax to 866-857-1144.

Plan Terminating

Plan Name	Carrier Name:	Employer Name:

Plan End Date	Plan Type (Select the one that applies)					
	Medical:	☐ HMO	☐ PPO	☐ POS	☐ Indemnity	
	Other:	☐ Dental	☐ Vision	☐ Rx	☐ Medical FSA	

Does this plan have a replacement plan that participants should be converted on to? ☐ Yes ☐ No

If yes, list plan name:

Plan Renewing

Plan Name	Carrier Name:	Employer Name:

Plan Renewal Date	Plan Type (Select the one that applies)					
	Medical:	☐ HMO	☐ PPO	☐ POS	☐ Indemnity	
	Other:	☐ Dental	☐ Vision	☐ Rx	☐ Medical FSA	

Is this plan 'bundled' together with other plans (participants are required to elect each of these plans to continue coverage)? ☐ Yes ☐ No

If yes, list plan names:

Is this plan intended to replace a previously existing plan? ☐ Yes ☐ No

If yes, list plan name:

Has the Eligibility Contact Changed? ☐ Yes ☐ No	Name of Eligibility Contact	Eligibility Contact's Telephone Number	**FAX Number**	E-mail	Customer Service Toll Free Number
		( ) -	( ) -		( ) -

Rates

Do not include the 2% COBRA Administration Fee

Employee Only	**Employee + Spouse**	**Employee + Child**	**Employee + Children**	**Spouse Only**	**Spouse + Child**	**Spouse + Children**	**Child Only**	**Children Only**	**Family**

Alternative Tier Structure (Not Recommended)

Individual Only	**Individual + 1**	**Individual + 2 or more**

Employer Representative - Form completed by:

Name	Title	Employer Name	Phone Number	E-mail
			( ) -	