Diversified Administration, Inc.
Tax Savings For Employers & Employees

PLEASE TYPE DIRECTLY ONTO THIS FORM

EMPLOYER INFORMATION

_____
Legal Name of Employer

_____
Address

_____
City, State, Zip

_____
Employer Tax I.D. Number

_____
Date Incorporated

_____
Operating Pursuant to the State Laws of

_____
Nature of the Business

_____
Web page

Total number of Employees: _____

Total number of Participants: _____

Are there any current COBRA Participants or Qualified Beneficiaries on the Plans? **Yes** _____ **No** _____
If Yes, please complete the Benefit Information below for both the current year and previous year.

Total number of Current COBRA Participants:
_____

Total number of Current Qualified Beneficiaries:
_____

Contact Information

_____
Name

_____
Title

_____
Telephone Number

_____
E-mail

_____
Fax Number

Billing Address (if different than Employer address)

_____

_____

Please complete the Benefit Information below for all COBRA eligible benefits. COBRA eligible benefits include:
HMOs
Group Insurance plans in which employees pay the premiums
Self –Insured medical reimbursement plans
Employee Assistance Plans
Health Flexible Spending Accounts
Defined Contribution (DC) Health Plans, including Health Reimbursement Accounts (HRAs)
Discount Programs
Wellness Programs
Treatment programs and clinics maintained by the employer (except first aid care provided free of charge to employees during working hours.

THE MONTHLY PREMIUM RATES ARE THE CARRIER COSTS WITHOUT THE 2% COBRA ADMINISTRATION FEE

COBRA Determination Plan Year: _____
Note: The COBRA Determination Plan Year is the year that COBRA rates are determined and frozen for that 12 month period. The beginning of the COBRA determination year is when you are allowed to change the COBRA rates and usually coincides with open enrollment of all benefits (under the Cafeteria Plan Year). However, if there is a rate renewal during the Determination Plan Year, you can not pass the rate increase on to COBRA participants until the beginning of the new Determination Year.

Open Enrollment Date for all Pre-tax Benefits:_____

BENEFIT INFORMATION

MEDICAL/PRESCRIPTION DRUG BENEFIT

Effective _____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

DENTAL BENEFIT

Effective_____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

BENEFIT INFORMATION

MEDICAL/PRESCRIPTION DRUG BENEFIT #2

Effective _____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

DENTAL BENEFIT #2

Effective_____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

BENEFIT INFORMATION

MEDICAL/PRESCRIPTION DRUG BENEFIT #3

Effective _____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

DENTAL BENEFIT #3

Effective_____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

VISION BENEFIT

Effective_____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:

- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

EMPLOYEE ASSISTANCE PLAN

Effective_____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + Family	_____
☐ Other	_____

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

OTHER BENEFIT

Description _____

Effective _____ **Rates Change** _____

Tier Name:	**Monthly Premium Rates:**
☐ Employee Only	_____
☐ Employee + One	_____
☐ Employee + Two	_____
☐ Employee + Spouse	_____
☐ Employee + 1 Child	_____
☐ Employee + 2 Child	_____
☐ Employee + Children	_____
☐ Employee + Family	_____
☐ Individually Rated	_____ (attach copy of rates)
☐ Flat Rate	_____
☐ Other	_____

What are the age limits of the Plan?
Dependent Age:_____ Student Age: _____

Date Termination of Coverage Becomes Effective:
- ☐ End of Month
- ☐ Date of Termination/Date of COBRA Event
- ☐ 30 Days After Termination
- ☐ End of Following Month After Termination
- ☐ 15th or 31st

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

Does the Carrier offer individual conversion policies after COBRA ends? Yes _____ No _____

Does the Carrier bill the participant at Home after COBRA coverage is elected? Yes _____ No _____

HEALTH FSA BENEFIT (Cafeteria Plan Year)

Plan Year Begins _____
Plan Year Ends _____
Carrier Information

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____

HEALTH REIMBURSEMENT ACCOUNT (HRA) BENEFIT

Effective_____ **Rates Change** _____

Monthly COBRA Premium Rate _____

Carrier Information

Carrier Name _____

Name of Plan: (HMO, PPO) _____

Group # _____

Contact _____

Phone # _____

Fax # _____

Address _____

City, State, Zip_____

Email: _____