Lifetime BENEFIT SOLUTIONS

Please email or fax completed form to your Dedicated COBRA Specialist:

Fax: 315.671.9869
Phone: 800.828.0078

BENEFIT PLAN SHEET – All information must be provided.

Client Information

Company Name: _____ Current # of benefit-eligible employees: _____

Contact Name: _____ Renewal Date: _____

Email Address: _____ Phone Number: _____

Plan Information ☐ New Plan ☐ Existing Plan – Renewal Only

Plan Name: _____

Carrier: _____ COBRA Group Number:_____

Plan Type: ☐ Medical ☐ Dental ☐Vision ☐ EAP ☐ FSA ☐ HRA ☐Other _____

Coverage Termination: ☐ Date of Event ☐ End of Month

☐ Self-Funded ☐ Fully Insured ☐ Remit to Client ☐ Remit to Carrier

Does this Plan offer Conversion? ☐ Yes ☐ No Disability Extension Fee: ☐ 2% ☐ 50%

Carrier Contact Information

Carrier Contact Name: _____

Email Address: _____

Phone Number: _____ Fax Number: _____

Plan Availability

Is the Plan available to all divisions? ☐ Yes ☐ No

If no, please list eligible divisions: _____

Monthly Premium (Do Not Include 2% Admin Fee)

QB Only: $ _____

QB+Spouse: $ _____

QB+Child: $ _____

QB+Children: $ _____

QB+Family: $ _____

Carrier and rate changes must be submitted 30 days prior to renewal. This will help ensure correct billing and remittance payments. Lifetime Benefit Solutions may not back-bill participants for untimely change notifications.