London Health Administrators
Health Care Saving Solutions

Contact Info:
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Employer COBRA Setup Form

Part 1: About Your Company

COBRA Effective Date:

Name of Business		Federal Tax ID #
Business Mailing Address (Street, City, Zip Code)		
Name of Executive Contact	Title	Phone #
Email Address of Executive Contact		
# of Active Employees Enrolled In Benefits As Of The Effecitve Date (Used for invoicing purposes throughout the year)		

Part 2a: COBRA Administration Information - Insurance Plan #1

Carrier Name	Insurance Type	Fully Insured (Yes or No)
Plan Name	Plan Policy #	Plan Anniversary Date

Carrier Contact To Receive COBRA Eligiblity Updates

Contact Name (or Department Name)	Phone #
Email Address	

Coverage Termination (please circle one): Date of Qualifying Event End of Month/Extended Notice Rule

Coverage Level	Monthly Premium (Previous Year)	Monthly Premium (Current Year)
Employee Only	$	$
Employee + Spouse	$	$
Employee + Child/ren	$	$
Family	$	$

Part 2b: COBRA Administration Information - Insurance Plan #2

Carrier Name	Insurance Type	Fully Insured (Yes or No)
Plan Name	Plan Policy #	Plan Anniversary Date

Carrier Contact To Receive COBRA Eligiblity Updates

Contact Name (or Department Name)	Phone #
Email Address	

Coverage Termination (please circle one): Date of Qualifying Event End of Month/Extended Notice Rule

Coverage Level	Monthly Premium (Previous Year)	Monthly Premium (Current Year)
Employee Only	$	$
Employee + Spouse	$	$
Employee + Child/ren	$	$
Family	$	$

Part 2c: COBRA Administration Information - Insurance Plan #3

Carrier Name	Insurance Type	Fully Insured (Yes or No)
Plan Name	Plan Policy #	Plan Anniversary Date

Carrier Contact To Receive COBRA Eligiblity Updates

Contact Name (or Department Name)	Phone #
Email Address	

Coverage Termination (please circle one): Date of Qualifying Event End of Month/Extended Notice Rule

Coverage Level	Monthly Premium (Previous Year)	Monthly Premium (Current Year)
Employee Only	$	$
Employee + Spouse	$	$
Employee + Child/ren	$	$
Family	$	$

Part 2d: COBRA Administration Information - Insurance Plan #4

Carrier Name	Insurance Type	Fully Insured (Yes or No)
Plan Name	Plan Policy #	Plan Anniversary Date

Carrier Contact To Receive COBRA Eligiblity Updates

Contact Name (or Department Name)	Phone #
Email Address	

Coverage Termination (please circle one): Date of Qualifying Event End of Month/Extended Notice Rule

Coverage Level	Monthly Premium (Previous Year)	Monthly Premium (Current Year)
Employee Only	$	$
Employee + Spouse	$	$
Employee + Child/ren	$	$
Family	$	$

Part 3: Employer Bank Account Information (Account Used To Remit COBRA Premiums To The Employer)

Financial Institution Name	Bank Account #	Routing #

Part 4: Signature and Agreement

1) I agrees to provide London Health Administrators with an updated eligibility list for employees covered by the group's insurance plan(s). When a participant is eligible for COBRA benefits, the employer agrees to notify London Health within ten business days indicating reason for termination.

2) I understand the COBRA member will submit COBRA premium payment to London Health Administrators and then London will submit the amount owed for the participant's coverage to the employer at the end of each month of coverage.

3) I understand that London Health is not financially liable to pay any insurance expenses and premiums for participants.

4) I understand this agreement will remain inforce from the effective date until a termination notice is sent from the employer.

5) I certify that the information in this agreement is true and complete.

6) I agree to the terms within this business agreement.

Signature of Authorized Executive	Title	Date