# COBRA Rate and Retiree Renewal Form

Ameriflex

*Page one must be completed for each carrier. For subsequent plans under the carrier, complete page two.*

## Client Information *(required)*

Company Name: ____________________ Current Number of Insured Employees: ________

Contact Name: ____________________ Renewal Date: ________

Email: ____________________ Telephone: ________

## Plan Information

COBRA ☐ SPM *(retiree)* ☐

Plan Name: ____________________

Carrier: ____________________ Group Number: ________

Plan Type: Medical ☐ Dental ☐ Vision ☐ EAP ☐ Cafeteria Plan ☐ HRA ☐ GAP ☐ Rx ☐ other ☐

Coverage Termination: Date of Event ☐ End of Month ☐ Wash/Roll ☐

Does the plan offer conversion?: Yes ☐ No ☐ Disability Extension Fee: 2% ☐ 50% ☐

If this plan is age banded, is renewal as of: Birthday ☐ Plan Anniversary ☐

## Eligibility Information

Carrier Contact Name: ____________________

Carrier Enrollment Contact Email: ____________________

Telephone: ____________________ Fax: ________

## Plan Availability

Is the plan available to all divisions?: Yes ☐ No ☐ Division ________

*Monthly Premium without 2% added:*

QB Only ________

QB + Spouse ________

QB + Child ________

QB + Children ________

QB + Family ________

Notes:

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

*Email the completed form to your Client Relationship Team* ***OR*** *mail the completed form to the following address:*

**Ameriflex** 2508 Highlander Way, Suite 200, Carrollton, TX 75006 **Attn:** COBRA Department

**Please reach out directly to your Client Relationship Team, whose information can be found under Ameriflex contacts in your user portal.**

*For subsequent plans under the carrier, complete this page.*

Company Name: ____________________ Carrier: ____________________

Additional Plans with Same Carrier (*Please list rates without 2% added.*): COBRA ☐ SPM ☐

Plan Name: ____________________ Sub-Group Number: ____________________

Plan Type: Medical ☐ Dental ☐ Vision ☐ EAP ☐ Cafeteria Plan ☐ HRA ☐ GAP ☐ Rx ☐ other ☐

QB Only ____________________

QB + Spouse ____________________

QB + Child ____________________

QB + Children ____________________

QB + Family ____________________

Notes:

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QB + Spouse ____________________

QB + Child ____________________

QB + Children ____________________

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QB Only ____________________

QB + Spouse ____________________

QB + Child ____________________

QB + Children ____________________

QB + Family ____________________

Notes:

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QB + Spouse ____________________

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QB + Spouse ____________________

QB + Child ____________________

QB + Children ____________________

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Plan Name: ____________________ Sub-Group Number: ____________________

Plan Type: Medical ☐ Dental ☐ Vision ☐ EAP ☐ Cafeteria Plan ☐ HRA ☐ GAP ☐ Rx ☐ other ☐

QB Only ____________________

QB + Spouse ____________________

QB + Child ____________________

QB + Children ____________________

QB + Family ____________________

Notes:

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