oca

NEW COBRA GROUP APPLICATION

V211123

Employer New Group Application

Client Information

Name:		
DBA (if applicable):		
Company address:		
City:	State:	ZIP Code:
Federal Tax ID:	Date Incorporated:	Organization is operating pursuant to the state laws of:

Total # of **Eligible** Employees: _____ Est. # of **Enrolled** Employees: _____ Request Employee Meeting: □ Yes □ No

Organization Type

☐ C-Corporation	☐ Sub-Chapter "S" Corporation
☐ Professional Corporation	☐ Professional Association
☐ Partnership	☐ Sole Proprietorship
☐ Government Agency	☐ LLC - Limited Liability Company
☐ Non-Profit	☐ Other: _____

Plan Administrator(s)

The "Signatory Contact" should be the individual authorized to sign/execute the legal plan documents at the organization. All individual(s) listed below will be provided with Employer Administrative Access, EFT Notifications, Check Register Notifications, COBRA Event Notifications, and any other

Signatory Contact:	Title/Position:
Signatory Email Address:	Signatory Phone #: Ext:
Primary Contact:	Title/Position:
Primary Email Address:	Primary Phone #: Ext.

Broker Contact Information

Broker Name:	Broker Firm:
Broker Email Address:	Primary Phone #: Ext:
Requesting commission to be collected and remitted to broker: ☐ Yes ☐ No (if yes, additional paperwork will be required from the broker)	General Agency Name:
☐ By checking this box, I, the client, am providing authorization to the above named-broker to be granted access to our company's data located on the OCA Employer web portal. This includes temporary reactivation/extension of debit card transactions.	☐ By checking this box, I, the client would like to authorize the above-named broker to provide employee additions, changes and terminations directly to OCA within 30 days of the event.

Client Invoicing Contact Information

Primary Contact:	Title/Position:	
Primary Email Address:	Primary Phone #:	Ext:
Mailing Address:		
City:	State:	ZIP Code:

Invoice Payment Set-up *(method used to remit OCA monthly and annual fees)*

☐ Company Check ☐ EFT – use same account as below ☐ EFT – use alternate account

If payment is being remitted via an EFT (Electronic Fund Transfer), please note that monthly invoices will be drawn on the 15th of each month. Annual fees are drawn in the month of the renewal date of the Plan for each line of service that applies. Should the 15th of the month happen to fall on a weekend, bank holiday or a day in which OCA is closed the funds will be drawn the business day prior. A surcharge of $45 will be assessed to those accounts in which funds were not available at time of draw. Additionally, all lines of service for said Company will be placed on hold until the payment is able to be collected.

Employer EFT SET-UP *(Please attach copy of the voided check(s) or letter from the bank)*

☐ We, authorize OCA to originate credit/debit entries to and from the below named account via EFT services provided

Bank Name:	
Routing Number (9 digit #):	Account Number:

Premium Disbursement *(Please provide the bank account information that you would like premiums remitted to)*

Bank Name:	Bank Account Type: ☐ Checking ☐ Savings
Bank Routing Number:	Bank Account Number:

Banking Authorization

☐ We authorize OCA to remit the COBRA monthly premiums via EFT to the employer bank account listed below. Premiums are remitted twice a month (if applicable). Should you prefer to receive the premiums via a check, please note there is a $2.00 fee per check issued.

Print Name:_____

Signature:_____

Date:_____

Premium Billing (COBRA, State Continuation, Direct Billing)

Are you subject to Federal COBRA or State Continuation?

☐ Federal COBRA ☐ State Continuation

Federal COBRA is federally guided and impacts employers with 20 or more employees during 50% or more of the prior year's total accumulation of business days. For employers subject to State Continuation or "mini-COBRA", individual State laws may vary, so please verify if OCA is able to administer your states continuation requirements.

Premium Billing Set up

OCA Start Date: _____/_____/_____
(MM/DD/YEAR)

Is this a takeover from another COBRA vendor? ☐ Yes ☐ No

Are there currently **ACTIVE COBRA** participants that OCA need to be aware of? ☐ Yes ☐ No

Are there currently **QUALIFIED BENEFICIARIES** within their election period? ☐ Yes ☐ No

Do **INITIAL NOTICES** need to be sent? ☐ Yes ☐ No

Eligibility Contacts

List any contacts (ex: Employer contacts or Broker contacts) that should receive emails regarding enrollment changes for COBRA participants.

☐ Employer Contact Listed on Application ☐ Broker Contact(s) Listed on Application ☐ Additional Contacts

If you selected additional contacts, please provide their contact information below.

Contact Name:	**Email:**	**Benefit Type:** Select
Contact Name:	**Email:**	**Benefit Type:** Select
Contact Name:	**Email:**	**Benefit Type:** Select
Contact Name:	**Email:**	**Benefit Type:** Select

*Benefit Type (I.e., Medical, Dental, Vision, etc.) will determine which benefit(s) OCA communicates enrollment changes associated to the participant. If the contact should receive communications for ALL benefits, please select enter "All Benefits"

Benefit Plan/Rate (1) Information	
Plan Type: Select Plan Type	**Carrier:**
Plan Name:	**Group Number:**
Is the plan: ☐ Fully Insured ☐ Self-funded	
Plan Effective Date: _____/_____/_____ *MM DD YYYY*	**Plan Ending Date**: _____/_____/_____ *MM DD YYYY*
When an Employee is terminated, what is the last day of active coverage: ☐ Last day of the Month in which they were terminated ☐ Date of termination ☐ Other: _____	
Max Children Charged (The number of children that can be counted towards the cost for Member-Level rates.)	**Max Child Age for Children Charged** (The max age of a child and student to be considered to the Max Children Charged determination.) **Student Age:**_____ **Child Age:**_____

Please indicate the rate type:

☐ Composite Rate Table ☐ *Age Banded Rate Structure ☐ * Other Tier Rating

Total **Monthly Employer** Rates ***(w/out 2% fee included)***:

Composite Rate Table	
Coverage Tier	**Premium**
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	

****If "Age Banded Rate Structure" or "Other Tier Rating" is selected, please include a copy of the required rates upon submission of the application form.****

Benefit Plan/Rate (2) Information	
Plan Type: Select Plan Type	**Carrier:**
Plan Name:	**Group Number:**
Is the plan: ☐ Fully Insured ☐ Self-funded	
Plan Effective Date: _____/_____/_____ *MM DD YYYY*	**Plan Ending Date**: _____/_____/_____ *MM DD YYYY*
When an Employee is terminated, what is the last day of active coverage: ☐ Last day of the Month in which they were terminated ☐ Date of termination ☐ Other: _____	
Max Children Charged (The number of children that can be counted towards the cost for Member-Level rates.)	**Max Child Age for Children Charged** (The max age of a child and student to be considered to the Max Children Charged determination.) **Student Age:**_____ **Child Age:**_____

Please indicate the rate type:

☐ Composite Rate Table ☐ *Age Banded Rate Structure ☐ * Other Tier Rating

Total **Monthly Employer** Rates ***(w/out 2% fee included)***:

Composite Rate Table	
Coverage Tier	**Premium**
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	

****If "Age Banded Rate Structure" or "Other Tier Rating" is selected, please include a copy of the required rates upon submission of the application form.****

Benefit Plan/Rate (3) Information

Plan Type: Select Plan Type	**Carrier:**
Plan Name:	**Group Number:**
Is the plan: ☐ Fully Insured ☐ Self-funded	
Plan Effective Date: _____/_____/_____ *MM DD YYYY*	**Plan Ending Date**: _____/_____/_____ *MM DD YYYY*

When an Employee is terminated, what is the last day of active coverage:

☐ Last day of the Month in which they were terminated

☐ Date of termination

☐ Other: _____

Max Children Charged (The number of children that can be counted towards the cost for Member-Level rates.)	**Max Child Age for Children Charged** (The max age of a child and student to be considered to the Max Children Charged determination.) **Student Age:**_____ **Child Age:**_____

Please indicate the rate type:

☐ Composite Rate Table ☐ *Age Banded Rate Structure ☐ * Other Tier Rating

Total **Monthly Employer** Rates ***(w/out 2% fee included)***:

Composite Rate Table	
Coverage Tier	**Premium**
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	

****If "Age Banded Rate Structure" or "Other Tier Rating" is selected, please include a copy of the required rates upon submission of the application form.****

Benefit Plan/Rate (4) Information

Plan Type: Select Plan Type	**Carrier:**
Plan Name:	**Group Number:**
Is the plan: ☐ Fully Insured ☐ Self-funded	
Plan Effective Date: _____/_____/_____ *MM DD YYYY*	**Plan Ending Date**: _____/_____/_____ *MM DD YYYY*

When an Employee is terminated, what is the last day of active coverage:

☐ Last day of the Month in which they were terminated

☐ Date of termination

☐ Other: _____

Max Children Charged (The number of children that can be counted towards the cost for Member-Level rates.)	**Max Child Age for Children Charged** (The max age of a child and student to be considered to the Max Children Charged determination.) **Student Age:**_____ **Child Age:**_____

Please indicate the rate type:

☐ Composite Rate Table ☐ *Age Banded Rate Structure ☐ * Other Tier Rating

Total **Monthly Employer** Rates ***(w/out 2% fee included)***:

Composite Rate Table	
Coverage Tier	**Premium**
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	

****If "Age Banded Rate Structure" or "Other Tier Rating" is selected, please include a copy of the required rates upon submission of the application form.****

Benefit Plan/Rate (5) Information

Plan Type: Select Plan Type	**Carrier:**
Plan Name:	**Group Number:**
Is the plan: ☐ Fully Insured ☐ Self-funded	
Plan Effective Date: _____/_____/_____ *MM DD YYYY*	**Plan Ending Date**: _____/_____/_____ *MM DD YYYY*

When an Employee is terminated, what is the last day of active coverage:

☐ Last day of the Month in which they were terminated

☐ Date of termination

☐ Other: _____

Max Children Charged (The number of children that can be counted towards the cost for Member-Level rates.)	**Max Child Age for Children Charged** (The max age of a child and student to be considered to the Max Children Charged determination.) **Student Age:**_____ **Child Age:**_____

Please indicate the rate type:

☐ Composite Rate Table ☐ *Age Banded Rate Structure ☐ * Other Tier Rating

Total **Monthly Employer** Rates ***(w/out 2% fee included)***:

Composite Rate Table	
Coverage Tier	**Premium**
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	

****If "Age Banded Rate Structure" or "Other Tier Rating" is selected, please include a copy of the required rates upon submission of the application form.****

Benefit Plan/Rate (6) Information

Plan Type: Select Plan Type	**Carrier:**
Plan Name:	**Group Number:**
Is the plan: ☐ Fully Insured ☐ Self-funded	
Plan Effective Date: _____/_____/_____ *MM DD YYYY*	**Plan Ending Date**: _____/_____/_____ *MM DD YYYY*

When an Employee is terminated, what is the last day of active coverage:

☐ Last day of the Month in which they were terminated

☐ Date of termination

☐ Other: _____

Max Children Charged (The number of children that can be counted towards the cost for Member-Level rates.)	**Max Child Age for Children Charged** (The max age of a child and student to be considered to the Max Children Charged determination.) **Student Age:**_____ **Child Age:**_____

Please indicate the rate type:

☐ Composite Rate Table ☐ *Age Banded Rate Structure ☐ * Other Tier Rating

Total **Monthly Employer** Rates ***(w/out 2% fee included)***:

Composite Rate Table	
Coverage Tier	**Premium**
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	
Select Coverage Type	

****If "Age Banded Rate Structure" or "Other Tier Rating" is selected, please include a copy of the required rates upon submission of the application form.****