e-mail: implementation@adminamerica.com ✯ Phone: 678-578-4626 ✯Toll Free: 1-800-366-2961

GEORGIA STATE CONTINUATION

For groups with Georgia-based medical plans that are not subject to Federal COBRA Laws. Please consult your broker and/or in-house counsel to verify COBRA/Continuation status. Admin America will be happy to assist in providing guidance, but the ultimate decision to offer State Continuation over COBRA is the responsibility of the Plan Administrator.

Customer Legal Name:					
Federal Tax ID Number:		**Total # of Employees**		**Admin Effective Date**	*
Physical Address					
Mailing Address	☐ Same as Above				
Customer Contact		**Title**			
Phone Number(s)	( ) - (ext.)	**E-mail**			
Alt. Customer Contact		**Title**			
Alternate Contact Phone	( ) - (ext.)	**E-mail**			
The Agency and contact listed below will be granted online access to this Client's Continuation Information through Admin America					
Broke r/ Agency Name					
Broker / Agent Name		Phone:	( ) - (ext.)		
Broker Customer Svc Rep / Acct Mgr		Phone:	( ) - (ext.)		
Email Addresses	Sales Rep/Broker/Agent	Account Manager or Service Representative			

The entity chosen below will be billed annually at $20.00 per continuation letter processed or re-processed and mailed. No monthly fees apply.

☐ Customer Primary Contact ☐ Customer Secondary Contact ☐ Other (pls. specify):

ONGOING CARRIER NOTIFICATION SERVICE OPTIONS (INITIAL ONE)	____ **STANDARD Carrier Notification Service** - Admin America's notifies the appropriate insurance carrier of the need to reinstate/re-enroll Continuation participants following receipt of their Continuation Election and receipt of their Initial Premium Payment. Please note Admin America does not terminate coverage with carrier(s). ____ **BROKER Notification Service -** Admin America's notifies the appropriate broker of the need to reinstate/re-enroll and terminate Continuation participants. The broker will initiate the appropriate activity with the carrier(s) upon notification. ☐ Notify the Customer too ____ **EMPLOYER PORTAL Notification Service** - The Client will secure clearance and access for Admin America to their Insurance Carrier(s) Employer Portal(s) – Granting Admin America authorization to add and/or terminate membership electronically. **Please note that under current law, Georgia State Continuation allows for a member to elect to remain on the Medical plan up to three months after their lose their eligibility.*
STATE CONTINUATION STATUS ***INITIAL NEXT TO EACH ITEM TO ACKNOWLEDGE***	____ ***As of the admin effective date, this group is not subject to COBRA.** ____ **COBRA requirements should be reviewed annually.** It is the responsibility of the Plan Administrator to communicate changes in COBRA Requirements to Admin America. *(If a party other than the plan administrator is completing this form, the party listed below will communicate the responsibilities of the plan to the plan administrator.)*

Admin★America

NEW CUSTOMER RATE WORKSHEET – MEDICAL PLAN(S) DUPLICATE PAGE AS NEEDED

MEDICAL PLAN 1

☐ HMO ☐ POS ☐ PPO ☐ OUT OF AREA PPO

1. **When will coverage end for terming Plan Members** ☐ Date of term ☐ Last day of month ☐ 15th or 31st Rule

2. **Plan Funding:** ☐ Fully Insured ☐ Self Insured

3. **Renewal Date:**

4. **Carrier Name:**

5. **Plan Name** (Buy-up; Core, etc.):

6. **Carrier Plan Division** (Ex: UHC-River Valley, Cigna - Great West, Aetna-Small Group, etc.):

7. **Group / Acct #:**

8. **Sub Account Code** (e.g. 001; 002):

9. **Carrier Contact (Account Manager):**

Name:

E-mail:

10. **Does the Medical plan include:** ☐ **Integrated HRA** (Participants may not opt out)

11. **Monthly Rates** (Do not include the 2% Administrative Fee)

	EE Only	EE & SP	EE& CH	FAM	EE + 1	EE + 2 or more
☐ Individually Rated (Census Included)						
☐ Age Banded (provided outside this form)	$	$	$	$	$	$

Notes:

MEDICAL PLAN 2

☐ HMO ☐ POS ☐ PPO ☐ OUT OF AREA PPO

1. **When will coverage end for terming Plan Members** ☐ Date of term ☐ Last day of month ☐ 15th or 31st Rule

2. **Plan Funding:** ☐ Fully Insured ☐ Self Insured

3. **Renewal Date:**

4. **Carrier Name:**

5. **Plan Name** (Buy-up; Core, etc.):

6. **Carrier Plan Division** (Ex: UHC-River Valley, Cigna - Great West, Aetna-Small Group, etc.):

7. **Group / Acct #:**

8. **Sub Account Code** (e.g. 001; 002):

9. **Carrier Contact (Account Manager):**

Name:

E-mail:

10. **Does the Medical plan include:** ☐ **Integrated HRA** (Participants may not opt out)

11. **Monthly Rates** (Do not include the 2% Administrative Fee)

	EE Only	EE & SP	EE& CH	FAM	EE + 1	EE + 2 or more
☐ Individually Rated (Census Included)						
☐ Age Banded (provided outside this form)	$	$	$	$	$	$

Notes:

ACCURATE INFORMATION ON THE RATE WORKSHEETS IS CRITICAL. REWORKS WILL RESULT IN A REPROCESSING FEE. $20 PER ELIGIBLE PLAN MEMBER TO BE CHARGED TO THE PREPARER.

PREPARED BY:	DATE: / /
SIGNATURE:	

Waiver Granting Online Access To Employer's COBRA Administration Information Via COBRA.adminamerica.com To Designated Health Insurance Agent

(This form is not to be used if Admin America also administers a Health FSA or a Health Reimbursement Arrangement for the Employer)

Employer:

I, the undersigned representative of the Employer named above, hereby authorize Admin America, Inc. (hereinafter "Admin America") to provide details regarding their administration of the named Employer's COBRA compliance to the individual(s) listed below. In granting this authorization I acknowledge the following:

a) this access will be provided via a secure online portal for which each individual granted access will be provided with a unique user name and password;

b) the information available includes names and addresses of Qualified Beneficiaries, the dates relevant COBRA notifications were sent to individuals, premium payments received by COBRA continuants and various deadlines related to the individual's specific COBRA circumstances;

c) the Employer may revoke this authorization at any time by notifying Admin America via e-mail sent to cobra@adminamerica.com. The e-mail should indicate the identity of the individual(s) whose access should be terminated. In addition, access granted to individuals affiliated with the Employer's health insurance agent or agency shall be deemed to be automatically revoked upon receipt of a notification by Admin America, Inc. that the Employer has retained a new agent of record for their health plan unless the Employer expressly directs Admin America otherwise; and

d) no access to Personal Health Information (PHI) (as defined under HIPAA) is granted under this authorization. Therefore, this authorization is not valid for Employer's for whom Admin America also provides administration services related to a Health FSA or a Health Reimbursement Arrangement. For such Employer's a separate authorization form compliant with HIPAA's Privacy Rules is required. That form is available from Admin America upon request;

Individual(s) Authorized To Access Online COBRA Information via COBRA.adminamerica.com:

(List names of individuals or as "Employees of ____________________ (agency name)")

Rep: ______________________________ Rep: ______________________________

______________________________ ______________________________

Email: (required) **Email: (required)**

______________________________ ______________________________

Signature of Employer's Authorized Representative Date

______________________________ ______________________________

Printed Name Title

Fax Completed Form to 770-670-6961 or scan and e-mail to implementation@adminamerica.com.

COBRA Third Party Administrator Take Over
Authorization to Transact Eligibility and Eligibility Inquiries

Date:

To:

From:

Group #:

As of ___/___/______ Admin America, Inc. has or will assume COBRA compliance for our organization.

We authorize employees of Admin America, Inc. to manage the COBRA administrative services on our behalf. This process will typically include electronic and/or telephonic transmission of eligibility.

We further authorize telephonic inquiry support for the employees of Admin America, Inc. surrounding eligibility.

Admin America, Inc.
1720 Windward Concourse, Suite 290, Alpharetta, GA 30005
678-578-4638
Federal ID: 20-3581707

This authorization will remain in effect until further notice.

Let Admin America know if you need anything further for authorization.

Thank you,

Authorization Signature: ______________________________

Name of Authorizing Rep ______________________________

Title ______________________________

Company ______________________________

Address ______________________________

Phone ______________________________

Fax ______________________________

Email ______________________________