North American
Benefits Company

Suite 310
20 Valley Stream Parkway
Malvern, Pennsylvania 19355

Email: cobra@nabenefits.com
Phone: 610-995-0169

COBRA NEW ACCOUNT SETUP

Employer Information:

Employer Name

Business Address | City | ST | Zip

Primary Contact | E-mail

Primary Contact Phone Number | Primary Contact Fax Number

Broker Name | Broker Phone Number

1. Federal Tax ID Number: _____ Total number of Employees: _____
   In the prior calendar year did your organization have a sufficient number of employees to fall under federal COBRA? ☐ Yes ☐ No
   (20 or more FT employees on ½ of typical business days in the prior year. Count PT employees as a fraction of a FT employee)
2. Requested effective date of COBRA Administration: _____
3. Initial / General Notice Processing:
   Select One:
   - ☐ NABCO will prepare and send each employee and spouse a COBRA Initial Notice. Employer must provide census information to NABCO in an outlined format. See attached price exhibit for cost.
   - ☐ NABCO will not prepare COBRA Initial Notices for current employees and spouses. The employer has provided a COBRA notice to all employees and spouses.
4. Are there any **current** COBRA Participants? ☐ No ☐ Yes (*If yes, please complete & attach COBRA Continuation Services form.)*
   (Report pending COBRA Qualifiers to NABCO only if they elect COBRA coverage.)
5. NABCO billing statement sent to: ☐ Employer ☐ Broker ☐ Other: _____

Signature of Employer or Authorized Representative | Print Name | Title | Date

Benefit Plan Information: (COMPLETE ONE SECTION FOR **EACH** PLAN)

Insurance Company | Plan Name

Address | City | ST | Zip

Contact Name | Phone Number

Plan Type: ☐ Medical ☐ Dental ☐ Vision **Benefits Plan Year:** _____ to _____ **Annual Open Enrollment Date:** _____

When is coverage effective for new hires? ☐ ___ Days ☐ ___ Months ☐ First of Month Following: ___ Days

When does coverage terminate? ☐ Date of COBRA Event ☐ End of Month

Original effective date of this plan? _____ Plan Renewal Date: _____

Does this plan offer conversion after COBRA ends? ☐ Yes ☐ No

What are the age limits of this plan? Dependent Age: _____ FT Student Age: _____

Current Rates Paid by Employer:

Employee: $_____ Employee & Spouse: $_____ Employee & Child(ren): $_____ Family: $_____

Employer Name: **Date:**

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If more space is needed for Benefit Plan information, please make an additional copy of this page