PRIMEPAY®

Benefit Services
New Business Onboarding Form

[Internal Use] Submitted By:				
Date Submitted:		Payroll Client #:		Office:

I confirm that to the best of my knowledge all the information provided is correct.

INSTRUCTIONS: Please do not print; complete each field (as applicable), and send to your PP team member.

Employer Information				
Legal Name:	DBA Name, if applicable:	EIN:		# of Total EEs:
Address:	City:	State:	Zip Code:	Main Phone #:

Primary Contact			
Name:	Title:		
Email Address:	Phone Number:	Extension:	Fax Number:

Secondary Contact			
Name:	Title:		
Email Address:	Phone Number:	Extension:	Fax Number:

Broker Contact			
Name:	Agency:		
Email Address:	Phone Number:	Extension:	Fax Number:

Authorized Contact for group: Yes No

Services to be Implemented & Service Start Date			
POP Start Date: End Date:	FSA # of Eligible EEs: Start Date:	HRA # of Eligible EEs: Start Date:	HSA # of Eligible EEs: Start Date:
Administrative Options: Self-Administered (Note: Plan Sponsor responsible for HRA MSP Reporting) PrimePay Administered (Default Administration)			
Parking/Transit Start Date:	Integrated Partner List Connected Platform:	COBRA: Premium Solution Start Date: Standard Solution Start Date: State Continuation for: ;	

Plan Status	
Does a POP/FSA Plan currently exist? No Yes If Yes, will this be an "amend and restate"? No Yes Original Plan Effective Date Original Plan #	Does a HRA Plan currently exist? No Yes If Yes, will this be an "amend and restate"? No Yes Original Plan Effective Date Original Plan #
If an HRA and FSA are both offered, which pays first? HRA FSA	Is there a Union? No Yes Union members included in the Plan(s)? No Yes

PRESS BUTTON TO CLEAR FORM

Tax Filing Status *2% or greater S-Corp Shareholders (includes spouse/family members), Sole Proprietors and Partners may not participate*			
☐ C-Corp	☐ S-Corp	☐ Partnership	☐ Sole Proprietor
☐ LLC	☐ Non-Profit	☐ Government	☐ Other:
For LLC, provide Tax Filing Status of ownership:			
☐ C-Corp	☐ S-Corp	☐ Partnership	

Please provide a list of 2% or more S-Corp Shareholders, Spouse/family members of 2% or more S-Corp Shareholders, Partners, Self-employed individuals, and Sole Proprietors who are not eligible to participate.

Affiliated Companies

Does another entity own interest in this company? ☐ No ☐ Yes [Provide information below]

If "Yes," do "Common Control Rules" apply for Nondiscrimination Testing? ☐ No ☐ Yes

Legal Name:	FEIN:	Affiliated Company Included in Plan?:		
		☐ No ☐ Yes		
Address:	City:	State:	Zip Code:	Main Phone #:

Do you own interest in any other business? ☐ No ☐ Yes [Provide information below]

If "Yes," do "Common Control Rules" apply for Nondiscrimination Testing? ☐ No ☐ Yes

Legal Name:	FEIN:	Affiliated Company Included in Plan?:		
		☐ No ☐ Yes		
Address:	City:	State:	Zip Code:	Main Phone #:

(Please provide a separate sheet for information on additional affiliated companies.)

Summary of Benefit Coverage Notice ***Please provide the following employee contact for the SBC Notices (HRA).*** ***Please note that each SBC in a non-English language will incur a separate fee.***		
Department Name:	Phone Number:	Website for Plan Documents:
Does one or more of your employees reside in a county where 10% or more of the population speaks a non-English language? If yes, please list the State and corresponding Counties: ☐ No ☐ Yes		
State/Counties:		

PRE-TAX ACCOUNT (FSA/HRA/HSA) PLAN CONTACT AUTHORIZATION			
The Plan Sponsor authorizes the following individuals to have access to Employer and Participant information, which includes the ability to enroll & terminate participants. Please use the notes section below if any individual should have limited access.			
Name:	Phone #:	E-Mail Address:	Receive Reports?
			☐ Daily claim check/debit card ☐ Monthly enrollee and pending
			☐ Daily claim check/debit card ☐ Monthly enrollee and pending
			☐ Daily claim check/debit card ☐ Monthly enrollee and pending
			☐ Daily claim check/debit card ☐ Monthly enrollee and pending
			☐ Daily claim check/debit card ☐ Monthly enrollee and pending

If Benefit Services does NOT issue the reimbursements, send Transaction Report ☐ Weekly ☐ Monthly

Send transaction reports to the following e-mail address: _____

NOTES:

Please provide any further explanations for Plan designs, questions about services, details that should be mentioned, etc.

Summary of HSA Plan & Benefits

Plan Year Starts On:

Is there a Union? ○ No ○ Yes,
Are Union Members included in the plan? ○ No ○ Yes

Does an HSA already Exist?

● No ○ Yes,
please list current Admin and Custodian Bank below:

Current HSA Custodian: _____

Current HSA Administrator: _____

Does/Did the Client Sponsor a general FSA in the current/ previous calendar year?

● No ○ Yes

Are Employee HSA Contributions included ○ No ● Yes
Employer HSA Contribution included? ● No ○ Yes,
please list the ER contribution below:

$ Employee Only
$ Employee + Dependents
$ Employee + Spouse
$ Family
$ Other

Which contribution methods will be offered?
☐ Non-elective ☐ Matching, Specify Below:

Employer HSA Contribution will be Funded:

Select From Below:

Will HCEs or Key Employees receive the HSA contribution?

☐ No ☒ Yes

Options:

Debit Card:
○ No
● Yes

HSA Accountholder Fee: $2.50 per month is paid by the account holder by default.
Does the client/employer want to pay? ● No ○ Yes
Manual Check Fee: $5.00 per check is paid by the account holder by default. Does the client/employer want to pay? ● No ○ Yes
Debit Card Replacements: $5.00 per replacement packet is paid by the account holder by default.
Does the client/employer want to pay? ● No ○ Yes

Participation and Eligibility Requirements for HSA Administration

Check the eligibility requirements for your employees and their respective maximums. If a category is checked but a maximum is not elected, it will be defaulted to the maximum. Check any or all that apply.

☐ All Employees
☐ Employees eligible for Group Health Benefit
☐ Employees eligible for specific group health plan:
☐ Employees reaching years of age will be included
☐ Employees expected to work at least hours per week will be included
☐ Employees meeting waiting period of days will be included (maximum 90 days)
☐ Date of Hire

Entry Date: Eligible employees begin participation in the Plan: (i.e. first day of month, same as group health, immediately)

Enrollment Option:
☐ Online Enrollment ☐ Integrated Partner:
☐ EDI Spreadsheet (attached separately)

Open Enrollment Period (required for online enrollment):
Begins: Ends:

Summary of HRA Plan & Benefits

Plan Year Starts On:	Plan Year Ends On:	Is this a Short Plan Year?	Is this a Take-Over?
		☐ No ☐ Yes	◯ No ◯ Yes

HRA Plan Type: ☐ General HRA ☐ Excepted D/V Benefit HRA ☐ Retiree HRA ☐ QSEHRA ☐ ICHRA ☐ EBHRA

Single Coverage: $_____ EE+1 Coverage: $_____ Family Coverage: $_____

Coverage: ☐ Aggregate ☐ Per Insured* # Family Deductibles have to settle:_____

ER Contribution: ☐ First Day ☐ Prorated If Prorated, contribute $_____ per _____

*Reminder: Debit Cards cannot be issued with plans with embedded/ per insured deductibles.

☐ First Dollar: 100% to Maximum

☐ First Dollar Percentage Split: _____% ER _____% EE

☐ ER/EE Split:

Single Benefit		Family Benefit	
1st Allocation $_____	Select	1st Allocation $_____	Select
2nd Allocation $_____	Select	2nd Allocation $_____	Select

☐ ER/EE Sandwich Split:

Single Benefit		Family Benefit	
1st Allocation $_____	Select	1st Allocation $_____	Select
2nd Allocation $_____	Select	2nd Allocation $_____	Select
3rd Allocation $_____	Select	3rd Allocation $_____	Select

☐ Please list other Plan design elements on page 3.

Will PrimePay administer the current Plan Run-Out Period? ◯ No ◯ Yes If yes, current plan design will be required for onboarding.

Benefits Included:

☐ Deductible Plans allowing: ☐ In-Network Only ☐ Out-of-Network Only ☐ Both	☐ Coinsurance ☐ Co-Pays ☐ Dental/Orthodontia ☐ STLDI: Short-Term Ltd Duration Ins	☐ ClaimsEssist Reminders: Provider Pay not included; Debit Cards must be restricted to RX Only; For Per Insured/Embedded Deductible Plans: **Dependent SSNs are Required**

☐ Rx (if separate deductible from medical plan, list benefit amount in notes section.)

☐ Individual Dental/Vision Insurance Premiums ☐ Individual Medical Insurance Premiums	☐ Uninsured Medical Exp (pursuant to IRC Section 213) ☐ COBRA Premiums ☐ Medicare Premiums	☐ Limited-Use HRA Dental, Vision and Preventative Care only	☐ Post-Deductible HRA (no reimbursement before the federal minimum deductible has been satisfied)

Options:

Debit Card: ☐ No ☐ Yes	Debit Card Restrictions: ☐ None ☐ Yes, and limited to:	Claim Run-out Period: ◯ None ◯ Yes, _____ days (Default is 90 days)	Carry-Over Option: ☐ No ☐ Yes: _____

Participation and Eligibility Requirements for HRA Administration

Check the eligibility requirements for your employee. Check any or all that apply.

☐ Employees enrolled in specific group health plan: _____

☐ Seasonal employees completing _____ months of work within a year will be included (maximum of 7 months)

☐ Employees expected to work at least _____ hours per week will be included

☐ Employees meeting waiting period of _____ days will be included (maximum 90 days)

Entry Date: Eligible employees begin participation in the Plan: _____ (i.e., first day of month, same as group health, immediately)

Other Elements:

- Is Direct Deposit authorized for Claim Reimbursements (Default is "Yes")? ◯ Yes ◯ No
- Have you submitted your Group Health Plan's copay summary matrix for Debit Card claim substantiation? ◯ Yes ◯ No
- If HSA eligible Plan, can employees opt to contribute to an HSA? ◯ Yes ◯ No
- May claim reimbursements be made to medical providers directly ('Provider Pay' Service; Default is "NO")? ◯ Yes ◯ No

MSP Mandatory Requirements for HRAs (Required for MSP reporting; ≥$5,000 benefit):

☐ Category 0: 1-19 Employees ☐ Category 1: 20-99 Employees ☐ Category 2: 100 or more Employees

Enrollment Option: ☐ Paper Enrollment ☐ Integrated Partner: _____ ☐ EDI Spreadsheet (attached separately)	Open Enrollment Period: Begins: _____ Ends: _____

Summary of FSA Plan & Benefits

Simple Cafeteria Plan (employer groups under 100 lives only): ☐ No ☐ Yes (Compliance review required, if selected)

Plan Year Starts On: _____	Plan Year Ends On: _____ Claim Run-out Period: ☐ None ☐ Yes, _____ days (Default is 90 days)	Is this a Short Plan Year? ☐ No ☐ Yes If plan has a Short Plan Year, EE annual maximum contribution cannot exceed x/12ths of IRS Max.	Is this a Mid-Yr Take-Over? ☒ No ☐ Yes Will PrimePay administer the current Plan Run-Out Period? ☒ No ☐ Yes
EE Contribution: Min. $_____ annually Max.$_____ annually	ER Contribution: ☐ No ☐ Yes Fixed Amount: $_____ Matching Amt: $_____	Cash Option: ☐ No ☐ Yes	If ER contribution limited to specific use, please specify: _____
Options:			
Debit Card: ☐ No ☒ Yes (FSA and Commuter Plans are issued Cards as default option)	Debit Card Restrictions: ☐ None ☐ Yes, and limited to:	Grace Period: ☐ None ☐ Yes, _____ days ☐ Health FSA ☐ DCAP	Carry-Over Option: ☐ No ☐ Yes, up to $_____

Participation and Eligibility Requirements for FSA/POP Administration

Check the eligibility requirements for your employees and their respective maximums. If a category is checked but a maximum is not elected, it will be defaulted to the maximum. Check any or all that apply.

☐ All Employees
☐ Employees eligible for Group Health Benefit
☐ Employees eligible for specific group health plan: _____
☐ Employees reaching _____ years of age will be included
☐ Employees expected to work at least _____ hours per week will be included
☐ Employees meeting waiting period of _____ days will be included (maximum 90 days)
☐ Date of Hire

Entry Date: Eligible employees begin participation in the Plan: _____ (i.e. first day of month, same as group health, immediately)

Enrollment Option: ☐ Online Enrollment ☐ Integrated Partner: _____ ☐ EDI Spreadsheet (attached separately)	Open Enrollment Period (required for online enrollment): Begins: _____ Ends: _____

Options:

Is Direct Deposit authorized for Claim Reimbursements (Default is "Yes")? ☐ Yes ☐ No

May claim reimbursements be made to medical providers directly ('Provider Pay' Service; Default is "NO")? ☐ Yes ☐ No

Have you submitted Group Health Plan's Co-Payment Summary matrix provided by your Carrier(s) for Debit Card claim substantiation? ☐ Yes ☐ No

Available Benefits - FSA/POP/HSA/Transportation Accounts

Select the benefits available to eligible employee(s). These benefits are taken through salary deductions.
Check any or all that apply)

Specify all applicable payroll deduction cycles for this benefit (12, 24, 26, 52) _____
First check date after effective date of plan: _____ Run date: _____
[**Please attach a payroll deduction schedule**]

- ☐ Health FSA – $_____ Maximum Annual Election (Default to annual Federal maximum limit)
- ☐ If at Federal maximum, please increase each year due to Federal COLA? (check box to confirm)
- ☐ Heroes Earnings Assistance and Tax Relief Act (HEART Act): Would you like to include language in your Plan regarding unused benefits in health flexible spending accounts of individuals called to active duty?
- ☐ Limited-Use Medical FSA - $_____ Maximum Annual Election
- ☐ Post-Deductible Medical FSA - $_____ Maximum Annual Election (Coordination with an HSA-qualified Plan)
- ☐ Dependent Care FSA (Annual Maximum $5,000, $2,500 if married filing separately)
- ☐ Premium Reimbursement Account (Individual Dental/Vision Premiums Only)
- ☐ Transit Spending Account (Covered under IRC Section 132); Employer will pre-fund monthly ___ or each payroll ___
  Employer Contribution Amount: _____
- ☐ Parking Spending Account (Covered under IRC Section 132); Employer will pre-fund monthly ___ or each payroll ___
  Employer Contribution Amount: _____

Premium Only Plan / Section 125 Cafeteria Plan (Check all applicable benefits below which employees contribute to on a pre-tax basis from payroll):

- ☐ If less than 20 employees, do you provide Federal COBRA benefits? ☐ No ☐ Yes
- ☐ Group Health Insurance
- ☐ Voluntary Term Life Insurance Premium (EE Only – Pre-tax up to $50,000 in death benefits.)
- ☐ Disability Insurance Premium (EE Only. If deducted Pre-tax, then paid benefits are taxable.)
- ☐ Cancer Insurance
- ☐ Dental Insurance
- ☐ Vision Insurance
- ☐ Accidental Death & Dismemberment
- ☐ Supplemental Health Insurance
- ☐ Other Insurance – Specify _____
- ☐ HSA: Are Employee HSA Contributions included? ☐ No ☐ Yes

  Employer HSA Contribution included? ☐ No ☐ Yes, please list the contribution below:
  - $_____ Employee Only
  - $_____ Employee + Dependents
  - $_____ Employee + Spouse
  - $_____ Family
  - $_____ Other

Client Information for COBRA Administration

PrimePay COBRA Solution		
How will PrimePay be notified of COBRA events?	How many health enrolled employees?	Have all currently enrolled participants received an Initial Rights Notice?
Select From Below		Select From Below
Present COBRA Administrator:	REMINDER: Transitioning to PrimePay at your Plan(s) Renewal?:	Are any enrolled and/or pending COBRA participants transitioning to PrimePay?
	Please include your previous **and** current Plan details and rates	Select From Below

PLAN CONTACT AUTHORIZATION

Please indicate additional individuals other than those on the first page of this form within your organization who require access to the Client Portal. We have provided space for up to six additional authorized users

Name	Title	Phone #	E-Mail Address

The individual listed under "Broker Contact" will have portal access unless you revoke their access. I do not wish for the individual listed under "Broker Contact" to have access to the portal.

Plan(s) to be Administered:
On the following pages, please provide the requested information on all plans requiring COBRA administration by PrimePay.
Examples: ***Medical, Dental, Vision, Medical Gap Coverage, Standalone Telemedicine, FSA, HRA, and/or EAP (Employee Assistance Plan)***

- If you have selected our **Standard Solution**, PrimePay will send notification of COBRA Elections/Terms to group contact who is responsible for sending to carrier for processing.
- If you have selected our **Premium Solution**, you must explain how PrimePay will pass election changes to the carrier.
  - Via Carrierôs Fax, Email, Portal, etc.
- If you have selected the optional **ñCarrier Remittanceò** service, you must provide the remittance address for each carrier to whom PrimePay will be sending premiums.

We have provided space for up to 8 plans; please contact us if you have more than 8 plans.

Benefit Administration Integrations -

bswift: (File Feed Timing - Each Thursday at 3am ET)
EmployeeNavigator: (File Feed Timing - Each Wednesday at 1am ET)

- PrimePay goes into the EN portal and runs the Plan Summary Report
- Fields Required:
  - #4, if different from Group ID; #8; #9; #10; #14 for Premium Solution
  - HRA and HFSA Premium Information

Ease: (File Feed Timing - Each Wednesday at 1am ET)

- Broker will generate the Configuration Report and send it to PrimePay
- Fields Required:
  - #4, if different from Group ID; #8; #9; #14 for Premium Solution
  - HRA and HFSA Premium Information

COBRA PLAN 1				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 2				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 3				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 4				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 5				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 6				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 7				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		

COBRA PLAN 8				
1. Plan Type:	2. Plan Name:			3. Effective Date:
Select From Below				
4. COBRA Group Number:	5. Carrier Name:		6. Participant Customer Service PH#:	
7. Type of Plan funding:	8. Plan written in what state?	9. Conversion avail?	10. Disability COBRA admin fee?	
Select From Below		Select From Below	Select From Below	
11. When does coverage end due to an employee's Qualifying Event (i.e., termination, reduction of hours)?		12. When does coverage end due to a dependent's Qualifying Event (i.e., divorce, ineligible dependent, death)?		
Select From Below		Select From Below		
13. Coverage Level & Rates For Age/Gender rates, please attach rate sheet.		14. PREMIUM SOLUTION: PrimePay is responsible for reporting enrollment updates to your carriers. Please explain how we will interact with the carrier.		
Employee Only		Name:		
Employee Only		Portal Credentials:		
Employee Only		Email:		
Employee Only		Phone #:		
Employee Only		Fax #:		