



**COBRA Administration
& Health Services, Inc.**

EMPLOYER QUESTIONNAIRE

Company Legal Name: _____

Contact Person: _____

Company Address: _____

_____ <i>City</i>	_____ <i>State</i>	_____ <i>Zip</i>
_____ <i>Phone</i>	_____ <i>Fax</i>	_____ <i>Email</i>

Total number of employees enrolled in all medical products: _____

Waiting period for new hires: _____

Dependent age maximum: _____ **Full-time student age maximum:** _____

Ineligible dependents covered until end of month or end of year: _____

Medical Carrier & Policy No. *(Attached bills or tables):* _____

Current Rates: _____

Renewal Date: _____

Will COBRA Administration process additions and/or terminations? Yes No Online Paper

Dental Carrier & Policy No. *(Attached bills or tables):* _____

Current Rates: _____

Renewal Date: _____

Will COBRA Administration process additions and/or terminations? Yes No Online Paper

Vision Carrier & Policy No. *(Attached bills or tables):* _____

Current Rates: _____

Renewal Date: _____

Will COBRA Administration process additions and/or terminations? Yes No Online Paper

	<u>FSA</u>	<u>HRA</u>
Policy No.:	_____	_____
Plan Year:	_____	_____
Vendor:	_____	_____
Contact:	_____	_____