

**COBRA/Employee Benefit Administrative Services
Employer Application**

Please complete this form and send to:
RP Riley Management Group Inc. • P.O. Box 149 • Mukwonago, WI 53149

Employer Name: _____ Total # of EE's _____

Contact: _____ Contact: _____

Address: _____

Phone #: _____ Fax #: _____ Email: _____

Send Correspondence to: _____

Branch: The above information is needed for each location. If you have more than one location, please list on a separate sheet of paper.

COBRA Information

Effective Date _____ # of current COBRA participants _____

COBRA participant start date: (check one) Monthly (1st of month after term) Daily (day after term) Other

If other, please explain: _____

Check the services you would like RP Riley Management to provide:

- General Notice Certificate of Creditable Coverage (HIPPA) Women's Health Cancer Rights Act

How should we mail? First Class E-mail to EE if allowed Certificate of Mailing (\$1.00 extra per letter)
 First Class cc to employer E-mail cc to employer
 Send COBRA Insurance Premiums to: Employer RP Riley Management Group Inc.

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Insurance Plan Information

Insurance Plan Year (i.e. Jan-Dec): _____ Open Enrollment Period: _____

New hire waiting period for coverage: _____ # of covered lives _____

Check all that apply to your benefit package:

- | | | | |
|---------------------------------|---|--|---|
| <input type="checkbox"/> Health | <input type="checkbox"/> Rx _____ (if separate) | <input type="checkbox"/> Flexible Spending Account | <input type="checkbox"/> EAP Program |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Rx Notification done by: _____ | <input type="checkbox"/> Self Funded | <input type="checkbox"/> Conversion Available |
| <input type="checkbox"/> Vision | _____ (name of carrier) | <input type="checkbox"/> Fully Insured | <input type="checkbox"/> 150% Rate for Disability |

Also submit the following: Employee census list of all active employees as well as current COBRA participants. Current Insurance rates for all plans.