COBRA Division Carrier & Rate Data

Please Note: ALL FIELDS ARE REQUIRED
Complete a section for each separate plan including Medical, Dental, Vision, EAP, FSA and HRA. To provide additional carrier and rate data, this form may be duplicated as needed.

Employer:

Carrier Name:		Group #:		Rates *Do not include 2% fee
Is This a New Plan?	Yes No	Is This a Self-Funded Plan?	Yes No	EE:
Plan Name:		Carrier Contact:		EE/Spouse:
Plan Year:		Carrier Phone:		EE/Child:
Carrier Email:		Carrier Fax:		EE/Family:
Coverage Termination	Date of Termination End of Month Other			EE/+1:

Individually Rated - Attach Schedule

Carrier Name:		Group #:		Rates *Do not include 2% fee
Is This a New Plan?	Yes No	Is This a Self-Funded Plan?	Yes No	EE:
Plan Name:		Carrier Contact:		EE/Spouse:
Plan Year:		Carrier Phone:		EE/Child:
Carrier Email:		Carrier Fax:		EE/Family:
Coverage Termination	Date of Termination End of Month Other			EE/+1:

Individually Rated - Attach Schedule

Carrier Name:		Group #:		Rates *Do not include 2% fee
Is This a New Plan?	Yes No	Is This a Self-Funded Plan?	Yes No	EE:
Plan Name:		Carrier Contact:		EE/Spouse:
Plan Year:		Carrier Phone:		EE/Child:
Carrier Email:		Carrier Fax:		EE/Family:
Coverage Termination	Date of Termination End of Month Other			EE/+1:

Individually Rated - Attach Schedule

Carrier Name:		Group #:		Rates *Do not include 2% fee
Is This a New Plan?	Yes No	Is This a Self-Funded Plan?	Yes No	EE:
Plan Name:		Carrier Contact:		EE/Spouse:
Plan Year:		Carrier Phone:		EE/Child:
Carrier Email:		Carrier Fax:		EE/Family:
Coverage Termination	Date of Termination End of Month Other			EE/+1:

Individually Rated - Attach Schedule

Please attach any plan summaries or SBCs if you would like Medcom to include them on the group's COBRA portal

Please complete entire form then submit to https://medcombenefits.com/form-carrier-and-rate.