

ADMINISTRATIVE PARTNERS

PO BOX 3050 ALLENTOWN, PA 18106
VOICE 610-432-1664 – FAX 610-433-5546

SERVICE AGREEMENT

THIS AGREEMENT is entered into this ____ day of _____, 20____, by and between **Administrative Partners** (the Company), whose address is PO Box 3050 Allentown, PA 18106 and:

Client Name (The Client)	
Plan Administrator Name & Title	
Address	
Phone/ Fax	
Email	
Number of Covered Employees	

For and in consideration of the mutual promises contained herein and other good and valuable consideration, the receipt of which is here by acknowledged, WHEREAS the Client is required to perform certain duties under the Group Plan Provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986(COBRA), (a); and WHEREAS the Company provides services to assist employers subject to the provisions of COBRA to comply with their duties and obligations under COBRA; and WHEREAS the Client and the Company desire to enter into an agreement in which the Company will assist the Client in COBRA administration.

NOW THEREFORE, the Client and the Company agree as follows:

I. DUTIES OF THE COMPANY.

The Company will provide the following services for consideration:

- (a) When a qualifying event occurs and we are informed, advise qualified beneficiaries and others covered under COBRA (the participants) in writing of their rights under current laws and regulations relative to continued coverage under the Client's group health plan(s);
- (b) When a new employee is hired and we are informed, provide the COBRA General Notice informing said employee of their rights under COBRA;
- (c) Advise and monitor the participants in the Client's group health plan(s) of the dates, which affect coverage, and elections of continuation coverage;
- (d) Advise the Client of changes in the laws and regulations regarding continued coverage under the group health plan(s) as they occur;
- (e) Collect premiums (plus administrative charges) from the participants electing continued coverage under the Client's group health plan(s), escrow premiums and remit them to the Client monthly less 2%.
- (f) Advise the Client of the status of each participant electing continued coverage under the Client's group health plan(s) on a monthly basis;
- (g) Provide the Client with a complete history by participant when suspended from this service indicating all relevant dates, payments, and elections regarding continued coverage under the Client's group health plan(s) as provided for by COBRA;
- (h) Provide the Client with forms to be used to notify the Company of Qualifying events
- (i) Provide the Client with changes in COBRA group health plan revisions, which may affect the administration and performance of this Agreement by the Company.

II. DUTIES OF THE CLIENT.

- 1. The Client shall advise the Company of the following events within thirty (30) days of the date the Client has knowledge of or receives notice of said event(s):
 - (a) Death of a covered employee;
 - (b) Termination of a covered employee (for reasons other than gross misconduct) or reduction in the employee's hours. The Client shall be solely responsible for determining whether or not an employee has been terminated for gross misconduct, as that term is defined by COBRA;
 - (c) Divorce/legal separation of covered employees;
 - (d) Covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
 - (e) Dependent children who cease to be covered as a "dependent" under the terms of the group health plan(s).
 - (f) Notify the Company of any changes to premiums at least 30 days before their effective date
- 2. If the Client wishes for Company to provide the COBRA General Notice, Client shall advise the Company of new members added to benefits within ninety (90) days of the date of benefit enrollment.

The Client agrees to inform the Company of any changes to the benefit plan at any given time, to ensure proper billing.

III. LIABILITIES AND RELEASE OF CLAIMS.

The Client agrees to indemnify and hold harmless the Company, and expressly agrees to release the Company from all claims and causes of action which result from the Client's failure to provide timely notification to the Company to satisfy COBRA Compliance or to comply with the terms of this agreement. Furthermore, the Company agrees to indemnify and hold harmless the Client, and expressly agrees to release the Client from all claims and causes of action which result from the Company's failure to satisfy COBRA Compliance or comply with the terms of this agreement.

IV. TERMINATION OF AGREEMENT.

Either party may terminate this Agreement by giving written notice to the other party, with said notice becoming effective upon the date of receipt of said notice. Within 30 days after the effective date of termination of this Agreement, the Company will provide the Client with a status report for each of the participants who were subject to this Agreement.

V. AMENDMENTS AND MODIFICATIONS.

This Agreement may be amended or altered, in whole or in part, only by the mutual agreement of the parties in writing. There are no oral or other agreements or understandings between the parties that affect this Agreement, and this Agreement supersedes all previous agreements between the parties.

VI. FEES

Full service Cobra Administration as described in this contract and HIPAA Notices:

\$0.79 per covered member per month / \$35 minimum per month per group

Is Broker responsible for this fee (circle one): Yes No

VII. MISCELLANEOUS

Monthly billing is provided for 2% of premiums collected.

This Agreement is to be governed and construed under the laws of the State of Pennsylvania. This Agreement shall be binding on the parties, their heirs, successors and assigns. IN WITNESS WHEREOF the parties have executed the within Agreement on the date first set forth above.

By: _____ Administrative Partners, (COMPANY)
(Name)

Signed _____ Date _____ AND

By: _____, (CLIENT)
(Name) (Company Name)

Signed _____ Date _____

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MEDICAL RATES

Effective Date _____

Do these rates include the 2% administrative fee Y / N

PLAN TYPE		
SINGLE		
EMPLOYEE/CHILD		
EMPLOYEE/CHILDREN		
EMPLOYEE/SPOUSE		
FAMILY		

DENTAL RATES

Effective Date _____

Do these rates include the 2% administrative fee? Y / N

Can this plan be elected as a stand alone? Y / N

PLAN TYPE		
SINGLE		
EMPLOYEE/CHILD		
EMPLOYEE/CHILDREN		
EMPLOYEE/SPOUSE		
FAMILY		

VISION RATES

Effective Date _____

Do these rates include the 2% administrative fee Y / N

Can this plan be elected as a stand alone? Y / N

PLAN TYPE		
SINGLE		
EMPLOYEE/CHILD		
EMPLOYEE/CHILDREN		
EMPLOYEE/SPOUSE		
FAMILY		

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Does your company offer a medical expense reimbursement program (FSA, Etc...)?

____ Yes ____ No

Does your company offer an EAP?

____ Yes ____ No

Does your company offer conversion rights?

____ Yes ____ No

When does employee coverage terminate after a qualifying event?

_____ Last day of the month

_____ Same day of qualifying event

_____ Day after qualifying event

When is a new hire eligible for benefits?

_____ Effective Date of Hire

_____ First day of month after Hire

_____ First of the month after _____ days of employment

Dependent cut off age:

Not attending school _____

Attending school _____

CARRIER INFORMATION

	MEDICAL	DENTAL	VISION
NAME			
ADDRESS			
CONTACT			
PHONE			
FAX			

Employer _____ Date ____/____/____

Completed By: _____

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Please complete for each current COBRA participant employer wishes to add to the Administrative Partners billing.

Name: _____

Address: _____

City/State/Zip: _____

Daytime Phone: _____

SSN _____ Event Type _____

Date of Birth: _____

Number of Months 18/29/36

COBRA Event Date ___/___/___

COBRA Effective Date ___/___/___

COBRA Coverage Type: Employee Only – Employee w/ Child(ren) – Employee/Spouse – Family

COBRA Coverage: Health – Dental – Vision

COBRA Premium _____ Include 2% Yes _____ No _____

Last Premium Paid \$ _____ on _____

Which pays through ___/___/___

Notes:

Name: _____

Address: _____

City/State/Zip: _____

Daytime Phone: _____

SSN _____ Event Type _____

Date of Birth: _____

Number of Months 18/29/36

COBRA Event Date ___/___/___

COBRA Effective Date ___/___/___

COBRA Coverage Type: Employee Only – Employee w/ Child(ren) – Employee/Spouse – Family

COBRA Coverage: Health – Dental – Vision

COBRA Premium _____ Include 2% Yes _____ No _____

Last Premium Paid \$ _____ on _____

Which pays through ___/___/___

Notes: