Independent Health℠
Dedicated to Making a Difference

# Group Direct Bill COBRA / NYSCOB Request Form

Dear Group Administrator:

Please complete the following and return it to your benefit consultant at:

Independent Health
511 Farber Lakes Drive
Buffalo, NY 14221
Attention: Sales Department

Group Name: _____ Group Number: _____

Group Address: _____ Phone Number: _____

Fax: _____

Please Print Name: _____

Authorized Signature: _____

Title: _____ Date: _____

By completing this form, I am requesting that Independent Health administer direct billing to all of our Group's Independent Health COBRA/New York State Continuation of Benefits (NYSCOB) members.

**Attached is our signed agreement.**

**AGREEMENT FOR COBRA AND**
**NEW YORK CONTINUATION OF BENEFITS PREMIUM BILLING**

**Effective _____ Independent Health Association, Inc.** ("Independent Health") and _____ (the "Employer") agree as follows:

1. On behalf of the Employer, Independent Health will, on a monthly basis, bill and collect premiums from those former employees and their dependents and other beneficiaries of the Employer's group health insurance plan who qualify for and elect to purchase continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or the continuation provisions of New York State Insurance Law ("Qualified Beneficiaries"). Benefits and premiums will correspond to those otherwise applicable under the Employer's plan, provided that Independent Health will add to each bill a charge for its billing service equal to two percent (2%) of the applicable premium, which service charge the Employer is hereby assigning to Independent Health.

2. Except as provided below, the Employer will have sole responsibility for complying with all notice requirements and election procedures under COBRA and the New York State Insurance Law and for determining who is eligible for continuation coverage under its group health insurance plan. The Employer will notify Independent Health in writing with respect to the commencement, termination and other terms and conditions of continuation coverage for each Qualified Beneficiary, and Independent Health will be entitled to rely upon those instructions. The Employer will have sole responsibility for notifying Cobra enrollees with plan choices upon renewal, and subsequently reporting requested plan changes to Independent Health.

3. It is agreed that Independent Health is not assuming responsibility for the Employer's obligations pursuant to COBRA or the New York State Insurance Law other than to bill and collect premiums according to the Employer's instructions. If Independent Health receives payment of less than the full amount of the applicable premium, Independent Health shall notify the Qualified Beneficiary and the Employer that if payment is not made within thirty (30) days, COBRA coverage shall terminate. This is the only COBRA notice that Independent Health will send. Independent Health shall notify the Employer when a Qualified Beneficiary's coverage is being termed for non-payment of premium.

4. The Employer will indemnify Independent Health from and against any and all claims, liabilities, costs or damages that arise as a result of the Employer's actions relative to the performance of this Agreement, including any failure to comply with the requirements of COBRA or New York State continuation of coverage provisions. The Employer's duty to indemnify will survive the termination of this Agreement for any reason.

5. Any party may terminate this Agreement by giving sixty (60) days written notice to the other parties.

**INDEPENDENT HEALTH ASSOCIATION, INC.**

**By: _____** **Date: _____**

**(EMPLOYER)**

**By: _____** **Date: _____**

# DIRECT BILL COBRA / NYSCOB INFORMATION FORM

(This form must accompany each direct bill COBRA application)

Account Name: _____

Account Number: _____

Subscriber ID Number: _____

Benefit Plan Name: _____

Qualifying Event: _____
(For example: Terminated, employment, reduction of hours, divorce, or dependent reached age limit)

COBRA Effective Date: _____ COBRA End Date: _____

I understand that the subscriber's rate will consist of our group rate plus a 2% administrative fee, calculated by using the total premium amount which is to include all riders and endorsements. Enclosed is our subscriber's enrollment application and first month premium.

_____ _____
(Group Administrator Signature) (Date)

_____ _____
(Please Print Administrator Name) (Phone Number)