# COBRA GROUP SET UP FORM

**EMPLOYEER INFORMATION**

Group Name: _____

Address: _____

City, State and Zip: _____

Phone Number: _____ Fax Number: _____

**CONTACTS**

| | NAME | PHONE | EMAIL |
|---|---|---|---|
| Primary: | _____ | _____ | _____ |
| Alternate: | _____ | _____ | _____ |

**PREVIOUSE CARRIER INFORMATION**

Name of Carrier: _____

Address: _____

City, State and Zip: _____

| Plans Offered | Tiers | Rates | Expiration Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**CURRENT COBRA PARTICIPANTS**

Do you have any current COBRA participants under previous carrier?

☐ Yes ☐ No (If Yes, please fill out COBRA notification form on each covered employee).

**EVERGREEN HEALTH PLAN, INC. WILL COMPLETE THIS SECTION:**

| **Plans** | **Tiers** | **Rates** | **Rates** |
|---|---|---|---|
| Preferred | Employee | _____ | _____ |
| Select | Employee + Spouse | _____ | _____ |
| Comprehensive | Employee + Child | _____ | _____ |
| Advantage POS | Family | _____ | _____ |
| Premium POS | | | |