PAYCHEX

# COBRA Employer Data Sheet

In order for Paychex to administer your continuation coverage, fill out this form completely and accurately and return to Paychex COBRA Department.

**COMPANY/CLIENT NAME:**_____ **OFFICE/CLIENT #:**_____

**ADDRESS:**_____ **CITY:**_____ **STATE:**_____ **ZIP:**_____

**TELEPHONE #: (** ____ **)**____ ____ **FAX #: (** ____ **)**____ ____ **E-MAIL ADDRESS:**_____

**CLIENT CONTACT NAME:**_____ _____
(First) (Last)

**Paychex Premier Client Effective Date:** ____/____/____
(The date you became a Paychex Premier Client)

**Effective Date of Information on this Form:**____/____/____

Check one:

- ☐ Original Employer Data Sheet (First Paychex submission for continuation coverage)
- ☐ Change (Submit at time of carrier and/or rate change)

Which defines your company policy concerning termination for group-sponsored coverage? (This will affect the continuation coverage)

- ☐ Insurance coverage terminates at the end of the month in which a qualifying event occurs
- ☐ Insurance coverage terminates on the qualifying event date

Employees reported in previous calendar year (by state)

State ____ Over 20 ☐ Yes ☐ No

State ____ Over 20 ☐ Yes ☐ No

State ____ Over 20 ☐ Yes ☐ No

***If there is a (plan) rate increase and/or carrier change, it is your responsibility to notify your Paychex COBRA Department of such changes.***

| **PLAN TYPE** (Check all that apply) | **GROUP #** | **NAME OF INSURANCE CARRIER** (e.g., Fortis Dental) | **NAME OF INSURANCE PLAN** (e.g., Select Silver) | **PREMIUM COSTS** (Carrier invoices for rates are not acceptable) | | **PLAN RENEWAL DATE** (Must complete) |
|---|---|---|---|---|---|---|
| ☐ **Medical**<br>**If Other, list Plan Type:** | | | | **Employee**<br>**Employee + Spouse**<br>**Employee + Child**<br>**Family**<br>**Other:** _____ | **$** \_\_\_\_<br>**$** ____<br>**$** \_\_\_\_<br>**$** ____<br>**$** ____ | |
| ☐ **Dental**<br>**If Other, list Plan Type:** | | | | **Employee**<br>**Employee + Spouse**<br>**Employee + Child**<br>**Family**<br>**Other:** _____ | **$** \_\_\_\_<br>**$** ____<br>**$** \_\_\_\_<br>**$** ____<br>**$** ____ | |
| ☐ **Vision**<br>**If Other, list Plan Type:** | | | | **Employee**<br>**Employee + Spouse**<br>**Employee + Child**<br>**Family**<br>**Other:** _____ | **$** \_\_\_\_<br>**$** ____<br>**$** \_\_\_\_<br>**$** ____<br>**$** ____ | |
| ☐ **Prescription**<br>**If not included with Medical Plan:** | | | | **Employee**<br>**Employee + Spouse**<br>**Employee + Child**<br>**Family**<br>**Other:** _____ | **$** \_\_\_\_<br>**$** ____<br>**$** \_\_\_\_<br>**$** ____<br>**$** ____ | |
| ☐ **Other**<br>**If Other, list Plan Type:** | | | | **Employee**<br>**Employee + Spouse**<br>**Employee + Child**<br>**Family**<br>**Other:** _____ | **$** \_\_\_\_<br>**$** ____<br>**$** \_\_\_\_<br>**$** ____<br>**$** ____ | |

*****IF YOU HAVE ADDITIONAL PLAN TYPES, COMPLETE AN ADDITIONAL EMPLOYER DATA SHEET*****

☐ I elect not to participate in the COBRA administrative services of Paychex.

**Name of person completing form:** _____ **Date:**____/____/____

Send completed form to Paychex. **Email:** APC_COBRA@paychex.com **Fax:** 585-249-4290
**Mail:** Paychex/ COBRA Department, **150 Sawgrass Dr, Rochester, NY 14620**

**NOTE: Incomplete Employer Data Sheets will be returned for missing information, which may result in delaying the start of continuation coverage for the qualified beneficiary.**