Bend Chamber of Commerce COBRA Outside Line Form

BenefitHelp SOLUTIONS

Instructions

1. Complete all sections of this form.
2. Return all documents to:
   BenefitHelp Solutions
   Email: bcocsales&service@benefithelpsolutions.com
   Phone: 503-412-4210

Only complete this form if there are plans outside of the Bend Chamber of Commerce you would like BenefitHelp Solutions to administer COBRA for.

BenefitHelp Solutions contact information:

Bend Chamber of Commerce Sales and Service Team
Email: bcocsales&service@benefithelpsolutions.com
Phone: 503-412-4210

Section 1 Company Information

Legal company name:	
Tax ID number:	

Section 2 COBRA Information for NON Bend Chamber Association Plans

Complete this section ONLY if you have COBRA qualifying plans outside of the Bend Chamber Association that you would like BHS to administer COBRA for.

Plan Type		
Carrier name:		Carrier ID:
Plan name:		Plan year:
Who should we send COBRA Premiums to?	☐ Send to carrier (common for Fully Insured Plans) ☐ Send to group (common for self funded plans) ☐ Combination ☐ Other _____	
Plan types:	☐ Standalone ☐ Bundled (plan must be elected with another plan, but has separate rates) ☐ Integrated (plan is combined with another plan type and has one combined rate.)	

Coverage Level	Premium Amount

Plan Type		
Carrier name:		Carrier ID:
Plan name:		Plan year:
Who should we send COBRA Premiums to?	☐ Send to carrier (common for Fully Insured Plans) ☐ Send to group (common for self funded plans) ☐ Combination ☐ Other _____	
Plan types:	☐ Standalone ☐ Bundled (plan must be elected with another plan, but has separate rates) ☐ Integrated (plan is combined with another plan type and has one combined rate.)	

Coverage Level	Premium Amount

Section 2.1 Carrier Contacts (remit address is required)

Complete this section if BHS will administer COBRA for any plans offered through carriers other than Providence, Delta Dental, or Willamette Dental.

Carrier name:			
Address to remit COBRA premiums to:	Street address:		
	City:	State:	Zip:
Remittance Contact Name:			
Remittance Contact Email:			
Remittance Contact Phone:			
Eligibility Contact Name:			
Eligibility Contact Email:			
Eligibility Contact Phone:			
Customer Service Contact Email:			
Customer Service Contact Phone:			

Carrier name:			
Address to remit COBRA premiums to:	Street address:		
	Ci ty:	State:	Zip:
Remittance Contact Name:			
Remittance Contact Email:			
Remittance Contact Phone:			
Eligibility Contact Name:			
Eligibility Contact Email:			
Eligibility Contact Phone:			
Customer Service Contact Email:			
Customer Service Contact Phone:			

Name:		Date:
Signature:		

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