Liz Manley Sales Representative
PacificSource Administrators
Return all documents to:
Johnson Benefit Planning - 541.382.3571
JBPadmin@johnsonbenefitplanning.com

COBRA Administration: BCOC Association

Company Name: _____

Documents Checklist:

• Complete this questionnaire (page 1)	• Signed HIPAA Business Addendum (pages 3-7)
• Signed COBRA Appendix A (page 2)	• Signed COBRA Administrative Agreement (pages 8-11)

Questionnaire:

1. How was COBRA administration previously handled?
   - ☐ Not previously COBRA eligible – skip to question 4
   - ☐ Internally
   - ☐ Vendor (TPA): Vendor Name ☐

2. COBRA Qualified Individuals:
   - ☐ Number of Current Continuants: *Provide a Current Continuant Form are those who have already elected COBRA and paid their premium through the end of the month prior to the PSA COBRA effective date. (Current Continuan Form located on page 12)*
   - ☐ Number of employee's who've experienced a Qualifying Event (QE) in the last 30 days: *Provide this information using a Notice of Qualifying Event Form. (Located on page 13)*

3. Current Continuants will be allowed an additional 15 days beyond the standard 30 day grace period to remit their first month's premiums.

4. Your group's administrative contact will automatically be provided access to our COBRA Web Portal. If you would like additional users, please provide their names and email addresses.

Name: _____ Email: _____

Name: _____ Email: _____

Information:

*5. **Would you like PSA to administer COBRA for your other carriers?***
PSA can administer COBRA for your other "ancillary" carriers. Group must have 20+ FTE employees and/or be COBRA eligible. Additional monthly fee may apply. Refer to the Appendix A (below). Email PSAsales@pacificsource.com to request the form in order to provide your additional carrier information.

- *Once the COBRA setup has been completed, PSA Sales will email a "Welcome Email" to the group administrator and agent with instructions, forms, and information indicating how to proceed during the year.*

PACIFICSOURCE ADMINISTRATORS, INC.

COBRA ADMINISTRATIVE AGREEMENT APPENDIX "A"

Employer's Legal Name	
Number of enrolled employees	
COBRA Effective Date*	
COBRA Renewal Date	
*Completed agreement must be received BEFORE the desired COBRA effective date, or the effective date will be moved to the 1st of the subsequent month .	

Fees charged by PacificSource Administrators, Inc.

The fees to provide plan set-up and administrative services, as outlined in this agreement, shall be as follows:

	PacificSource BCOC Association
Initial Setup Fee	Included in PSHP Premium
Annual Renewal Fee	Included in PSHP Premium
Monthly Administrative Fee	Included in PSHP Premium
Blanket Initial Notices	Included in PSHP Premium
PSA can administer COBRA for all your other carriers for an additional $50 per month. Group must have 20+ FTE employees and/or be COBRA eligible.Selection of this service must be indicated on the Questionnaire, and an ancillary design guide containing carrier and plan information must be returned prior to the effective date.	

Termination from the BCOC Association will result in COBRA Administrative Fees being billed to the group the following month, at a rate of $75.00 per month for the remainder of the Plan Year. Fees will be re-assessed upon renewal and the group will be responsible for said fees.

In addition to the fees listed above, PacificSource Administrators, Inc. will retain the 2% administrative fee collected for each qualified beneficiary electing COBRA continuation.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement and the Appendix "A" of this Agreement in duplicate.

Employer **PacificSource Administrators, Inc.**

Signature:_____ By:

Name:_____ Name: Kenneth P Provencher

Title:_____ Title: President and CEO

Company:_____ Company: PacificSource

Date:_____ Date: _____

PacificSource ADMINISTRATORS

Business Associate Addendum – Please Sign and Return

Enclosed for your review and signature is a revised Business Associate Addendum. This document is considered an addendum to the main agreement between our companies.

- **Review** the enclosed addendum.
- **Sign** the addendum to acknowledge that your company currently has in place all of the safeguards, policies, etc. that are required.
- **Retain** a copy for your records.

Why am I being asked to sign this? The American Recovery and Reinvestment Act of 2009 (ARRA) contained a variety of provisions related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Essentially, ARRA now makes business associates responsible for certain privacy and security provisions contained in the HIPAA regulations.

Thank you! We appreciate your help in meeting the requirements of this federal law and thank you in advance for returning your signed addendum promptly. If you have any questions, please feel free to contact our Sales and Service Department at psasales@pacificsource.com or (800) 422-7038.

Enclosures

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum supplements and is made a part of the Agreement ("Agreement") by and between the Plan Sponsor of the Covered Entity ("Employer") and PacificSource Administrators, Inc. ("Business Associate") dated effective the 1st day of _____ (the "Effective Date").

RECITALS

A. Employer wishes to disclose certain information ("Information") to Business Associate pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI").

B. Employer and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to the Business Associate pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and regulations promulgated thereunder ("the HIPAA Regulations"), the American Recovery and Reinvestment Act of 2009, and regulations promulgated thereunder (collectively, "ARRA"), and other applicable laws.

C. The purpose of this Addendum is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, including, but not limited to, Title 45, Section 164.504(e) of the Code of Federal Regulations ("CFR"), as the same may be amended from time to time.

In consideration of the mutual promises below and the exchange of information pursuant to the Agreement, the parties agree as follows:

1. Definitions. Capitalized terms used herein without definition shall have the meanings assigned to such terms in the Agreement, 45 CFR Parts 160 and 164, or in the ARRA. "Employer" shall mean the entity designated on the last page of this Addendum, which is the Plan Sponsor of the Covered Entity.

2. Obligations of Business Associate.

(a) Permitted Uses and Disclosures. Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity, and to otherwise satisfy its obligations under the Agreement, as permitted herein, or required by law, but shall not otherwise use or disclose any PHI.

(b) Safeguards. Business Associate shall use commercially reasonable safeguards to prevent use or disclosure of PHI other than as provided for by this Addendum. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of Covered Entity, as required by 45 CFR 164.314(a)(2)(i)(A).

(c) Reporting of Disclosures. Business Associate shall report to Employer any use or disclosure of PHI otherwise than as provided for by this Addendum of which Business Associate becomes aware. Business Associate shall also report to Employer any Security Incident related to PHI of which Business Associate becomes aware.

(d) Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of this Addendum.

(e) Business Associate's Agents. Business Associate shall ensure that any agents, including subcontractors, to whom it delegates any function or activity it has undertaken to perform on behalf of Covered Entity, and to whom it provides PHI received from (or created or received by Business Associate on behalf of) Covered Entity, agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI.

(f) Availability of Information to Employer. Business Associate shall make available to Employer such information as Employer may require to fulfill the obligations of Covered Entity to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.524 and 164.528.

(g) Amendment of PHI. Business Associate shall make PHI available to Employer as Employer may require to fulfill Covered Entity obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526 and Business Associate shall, as directed by Employer, incorporate any amendments to PHI into copies of such PHI maintained by Business Associate.

(h) Internal Practices. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI received from (or created or received by Business Associate on behalf of) Covered Entity available to the Secretary for purposes of determining the compliance of Covered Entity with HIPAA and the HIPAA Regulations.

(i) Documentation and Accounting of Disclosures. Business Associate shall document disclosures of PHI, and provide such information, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR Section 164.528.

(j) Notification of Breach. During the term of this Addendum, Business Associate shall notify Employer as soon as reasonably practical of any suspected act or actual Breach of security, intrusion or unauthorized use or disclosure of PHI and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

(k) Obligations Imposed by the American Recovery and Reinvestment Act of 2009. Business Associate agrees to comply with all applicable provisions of the ARRA, and any regulations or guidance promulgated or issued thereunder, as of the effective date of those provisions, including without limitation compliance with the Security Rule and the Breach notice requirements.

3. Obligations of Employer.

   (a) Safeguards. Employer shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate pursuant to this Addendum, and in accordance with the standards and requirements of HIPAA, the HIPAA Regulations, and ARRA, until such PHI is received by Business Associate; at a minimum Employer shall ensure that all electronic PHI is encrypted. Employer shall be responsible to send any and all notifications required under ARRA.

   (b) Notification of Limitations. Employer shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity in accordance with 45 CFR Section 164.520, to the extent that such limitations may affect Business Associate's use or disclosure of PHI.

   (c) Notification of Changes. Employer shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

   (d) Notification of Restrictions. Employer shall notify Business Associate of any restriction to the use or disclosure of PHI that Employer has agreed to in accordance with 45 CFR Section 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

   (e) Compliance. Employer shall not act or fail to act in a manner that would cause Business Associate to violate or not be in compliance with this Addendum, applicable state and federal law, including HIPAA and ARRA. Employer acknowledges that it is not Business Associate's responsibility or obligation to ensure that Employer and/or Covered Entity so comply.

4. Termination.

   (a) Reasonable Steps To Cure Breach. If Employer knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under the provision of this Addendum or another arrangement and does not terminate the Agreement pursuant to the termination provisions of the Agreement, then Business Associate shall take reasonable steps to cure such breach or end such violation as applicable. If Business Associate's efforts to cure such breach or end such violation are unsuccessful, then a material breach exists and Employer may terminate the Agreement in accordance with its terms.

   (b) Effect of Termination. Upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Employer (or created or received by Business Associate on behalf of Employer) that Business Associate still maintains in any form and shall retain no copies of such PHI or, if the return or destruction is not feasible, it shall continue to extend the protections of this Addendum to such information.

5. Indemnification. Each party will indemnify, hold harmless and defend the other party to this Addendum from and against any and all claims, losses, liabilities, cost and other expenses incurred as a result of, or arising directly or indirectly out of or in connection with any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the party under this Addendum and any claims, demands, awards, judgments, actions and proceedings made by any person or organization arising out of or in any way connected with the party's performance under this Addendum; provided, however, that Business Associate shall have no responsibility for any and all expenses related to any notifications required under state or federal law.

6. Disclaimer. Business Associate makes no warranty or representation that compliance by Employer with this Addendum, HIPAA, the HIPAA Regulations, or ARRA will be adequate or satisfactory for Employer's own purposes or that any information in Employer's possession or control or transmitted or received by Employer, is or will be secure from unauthorized use or disclosure. Employer is solely responsible for all decisions made by Employer regarding the safeguarding of PHI.

7. Amendment To Comply With Law. The parties acknowledge that state and federal laws relating to Electronic Data Security and privacy may be evolving and that the amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations, ARRA, and other applicable laws relating to the security and confidentiality of PHI.

8. Interpretation. The parties agree that this Addendum shall not be more strictly interpreted or construed against the drafter of this Addendum, as the parties agree and acknowledge that all parties, directly or through their agents, have participated in the preparation or negotiation of this Addendum.

9. No Third Party Beneficiaries. Nothing expressed or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Employer, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

10. Survival. The respective rights and obligations of Business Associate under section 4(b) shall survive termination for so long as Business Associate maintains PHI.

11. Effect On Agreement. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect.

12. Interpretation. This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations, ARRA, and applicable state laws. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HIPAA Regulations, and ARRA.

IN WITNESS WHEREOF, the parties hereto have duly executed this Addendum as of the Effective Date.

Employer	**PacificSource Administrators, Inc.**
Signature: _____	By _____
Name: _____	Name: Kenneth P Provencher
Title: _____	Title: President and CEO
Date: _____	Date: _____

PACIFICSOURCE ADMINISTRATORS, INC.
COBRA ADMINISTRATIVE AGREEMENT

This Administration Agreement is made and entered into by and between PacificSource Administrators, Inc., an Oregon corporation and _____ and provides as follows:

Recitals

WHEREAS, PacificSource Administrators, Inc. provides COBRA benefits to "qualified beneficiaries" in compliance with ERISA; and

WHEREAS, the Employer, with the assistance of PacificSource Administrators, Inc., has enrolled "qualified beneficiaries" for COBRA benefits; and

WHEREAS, the Employer desires to have PacificSource Administrators, Inc. administer the COBRA benefits;

NOW, THEREFORE, in consideration of the premises and of the mutual Agreements contained herein, and for other good and valuable consideration, the sufficiency and receipt of which is hereby acknowledged, the parties agree as follows:

1. Engagement of Administrator.

The Employer hereby engages PacificSource Administrators, Inc. as the administrator of COBRA benefits on the terms and conditions provided in this Agreement.

2. Administration Fee.

The Employer agrees to pay any applicable administration fees set forth in the Master Agreement with PacificSource Health Plans. Such fees represent maintenance fees for maintaining the physical and computer records for each "qualified beneficiary," through the required period of coverage.

3. Plan Administration.

A. Beneficiary Notification.

PacificSource Administrators, Inc. shall provide qualified beneficiaries with notification of continuation rights within fourteen days of receiving notice of a qualifying event. In addition, PacificSource Administrators, Inc. will provide qualified beneficiaries with notice of changes in plan provisions if it should become effective during the coverage period. All notifications provided by PacificSource Administrators, Inc. will include any and all statutorily required provisions and disclosures.

B. Collection of Premiums.

PacificSource Administrators, Inc. shall be responsible for the collection of premiums from qualified beneficiaries electing COBRA coverage and for the distribution of the beneficiary's premiums to the Client, less a 2% administrative fee.

C. Maintenance of Records.

PacificSource Administrators, Inc. agrees to maintain sufficiently detailed physical and/or computer records regarding qualified beneficiary notification, beneficiary election (or waiver) of benefits, and notification of conversion. Periodically, PacificSource Administrators, Inc. shall deliver a status report to the Employer regarding the plan. PacificSource Administrators, Inc. shall maintain and keep all records including worksheets, receipts, and vouchers for seven (7) years after the documents to which they relate are filed unless otherwise exempted. PacificSource Administrators, Inc. shall transfer all records to successor plan administrator if requested by the Employer in writing.

D. Required Reporting.

PacificSource Administrators, Inc. shall provide any federal or state agency with required reports which contain information over which PacificSource Administrators, Inc. has control and that PacificSource Administrators, Inc. generates in accordance with this Agreement.

E. Beneficiary Requests for Information.

PacificSource Administrators, Inc. shall furnish any qualified beneficiary with plan information upon the beneficiary's written request.

4. Confidentiality.

PacificSource Administrators, Inc. acknowledges that information of the Employer's and its employees represents confidential and proprietary information. In return, the Employer acknowledges that information provided by or concerning PacificSource Administrators, Inc. is confidential and proprietary property of PacificSource Administrators, Inc.. Both parties agree to maintain the confidentiality of information obtained about the other party during the term of this Agreement, and agree not to disclose any such information to any third party without the prior written consent of the other party. This Agreement regarding confidentiality shall survive the termination of this Agreement.

5. Not a Fiduciary or Plan Administrator.

The parties acknowledge that since PacificSource Administrators, Inc. only performs functions that are administrative in nature, PacificSource Administrators, Inc. shall not be deemed a fiduciary, as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"). Nothing in this Agreement shall be construed as an appointment of PacificSource Administrators, Inc. as the administrator of the plan, as the term is defined in the health plan and by ERISA. PacificSource Administrators, Inc. is retained to perform services as an administrator, functioning as an agent of the plan administrator. Nothing in this Agreement shall relieve the plan sponsor or the plan administrator of any of the responsibilities they assume by adopting or executing the plan or by operation of law.

6. Limitation of Liability.

The Employer agrees to indemnify and hold PacificSource Administrators, Inc., its officers, agents and employees harmless against any and all loss, damage, interest, costs and expenses, including attorney's fees, occasioned by claims, demands or lawsuits brought against PacificSource Administrators, Inc. related to the group insurance programs for which PacificSource Administrators, Inc. provides administrative services, or to the extent such damages arise from or are related to inaccurate or untimely submission of information to PacificSource Administrators, Inc., or for the Employer's performance of its duties hereunder. PacificSource Administrators, Inc. agrees to indemnify and hold the Employer, its officers, agents and employees harmless against any and all loss, damage, interest, costs and expenses, including attorney's fees, occasioned by claims, demands or lawsuits brought against the Employer to the extent such damages are reasonably ascertainable and only to the extent that such damages are the direct and proximate results of a PacificSource Administrators, Inc. breach of administrative responsibilities, as defined in this Agreement. In no event shall PacificSource Administrators, Inc. be responsible for special, indirect, incidental, or consequential damages which the Employer or any third party may incur or experience by reason of entering into or relying on this Agreement.

7. Resignation and Removal.

PacificSource Administrators, Inc. may resign or may be removed by the Employer at any time, with or without cause. Such resignation or removal shall be accomplished by the giving of sixty (60) days advance written notice, except in the event of gross negligence, criminal activities or such other serious cause in which case the Employer shall have the power to terminate this Agreement as of the date of notice to PacificSource Administrators, Inc.. Upon resignation or removal, the Employer shall appoint a successor to whom PacificSource Administrators, Inc. shall transfer all documents and records held by PacificSource Administrators, Inc. along with funds in custody of PacificSource Administrators, Inc.

8. Miscellaneous.

This Agreement constitutes the entire understanding and Agreement of the parties and may be modified only by a subsequent writing signed by both parties. The Employer acknowledges that there have been no other representations or warranties made by PacificSource Administrators, Inc. or the Employer which are not set forth in this document.

9. Assignability.

This Agreement may not be assigned by the Employer without the prior written consent of PacificSource Administrators, Inc. Any assignment made without such consent shall be null and void.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed the _____ day of _____**,** 20___.

Employer	**PacificSource Administrators, Inc.**
By: _____	By: _____
Name: _____	Name: Kenneth P Provencher
Title: _____	Title: President and CEO
Company:_____	Company: PacificSource
Date: _____	Date: _____

PacificSource.com/PSA
Phone: 877-355-2760 Fax: 541-225-3684
PO Box 71096, Springfield, OR 97475
cobra@pacificsource.com

COBRA Current Continuant Information Form

Step 1: **Continuant Information** *=Required

*Employer Name (do not abbreviate) | *Division Name (if applicable)

*Continuant Status: ☐ Former Employee ☐ Not Employee (spouse or dependent) ☐ Current Employee

*Continuant Name | *Social Security Number

*Mailing Address | *City | *State | *Zip

*Date of Birth (mm/dd/yyyy) | *Gender (M/F) | Daytime Phone

*If continuant named above is not a current or former employee but is a spouse or dependent, please provide the employee name and SSN

Employee Name | Employee SSN

Step 2: Event Information

*Qualifying Event Date (mm/dd/yyyy)

*Qualifying Event Type:

- ☐ Voluntary Termination
- ☐ Involuntary Termination
- ☐ Reduction in Hours (if reduction to zero hours, mark as involuntary termination)
- ☐ Employee Covered by Medicare
- ☐ Death of Covered Employee
- ☐ Divorce/Legal Separation
- ☐ Child Losing Dependent Status

*First Date of Active Coverage (mm/dd/yyyy) | *First Date of COBRA Coverage (mm/dd/yyyy)

Last Date of Active Coverage (mm/dd/yyyy) | Last Date of COBRA Coverage (mm/dd/yyyy)

Step 3: Payment Information

*COBRA Coverage Paid Through Date (mm/dd/yyyy) **note**: must be at least end of the month prior to effective date to process

Step 4: Plan Information

*Current Benefits with Plan Description (e.g.. HMO, PPO, etc.)

☐ Medical		☐ EE Only	☐ EE+SP	☐ EE+CH(ren)	☐ Family	
☐ Dental		☐ EE Only	☐ EE+SP	☐ EE+CH(ren)	☐ Family	
☐ Vision		☐ EE Only	☐ EE+SP	☐ EE+CH(ren)	☐ Family	
☐ Medical Spending Account (FSA)	*Monthly Rate: $	*Plan Year End Date: (mm/dd/yyyy)				
☐ Other		☐ EE Only	☐ EE+SP	☐ EE+CH(ren)	☐ Family	

Step 5: Other Covered Family Members

***Spouse Name** (if applicable)

*Date of Birth (mm/dd/yyyy) | *Spouse SSN | Address Same as Continuant (Y/N)?

***Dependent Child 1 Name**

*Date of Birth (mm/dd/yyyy) | *Dependent SSN | Address Same as Continuant (Y/N)?

Dependent Child 2 Name (if applicable, please attach another form for additional covered dependents)

*Date of Birth (mm/dd/yyyy) | *Dependent SSN | Address Same as Continuant (Y/N)?

Step 6: Additional Information: Select all that apply. Social Security Disability Extension ☐ State Continuation ☐

Step 7: Employer Authorization

I hereby certify that the information contained above is accurate to the best of my knowledge. I understand that PacificSource Administrators will not be held liable for missing or inaccurate information.

*Completed By: | *Daytime Phone Number | *Date:

PacificSource.com/PSA
Phone: 877-355-2760 Fax: 541-225-3684
PO Box 71096, Springfield, OR 97475
cobra@pacificsource.com

COBRA Notice of Qualifying Event Form

Step 1: **Employee Information** *=Required

*Employer Name (do not abbreviate)

*Division Name (if applicable)

*Employee Name (First, Middle Initial, Last)

*Gender (M/F)

*Date of Birth (mm/dd/yyyy)

*Hire Date (mm/dd/yyyy)

*Social Security Number

*Mailing Address

Daytime Phone

*City

*State

*Zip

Step 2: ***Qualifying Event Information**

*Date of Qualifying Event (mm/dd/yyyy)

*Original Enrollment Date/Hire Date

- Voluntary Termination*
- Involuntary Termination*
- Reduction in Hours
- Retirement
- Loss of Eligibility
- Employer Bankruptcy
- Reservist called to Active Duty

***Notice of Unavailability:**

- N/A
- Yes, please indicate reason:
- Gross Misconduct*
- Termination prior to active benefit(s)
- Other, please explain:

***Please note:** Termination due to gross misconduct makes an employee and family members ineligible for COBRA coverage. If termination is due to gross misconduct, please document the reason for gross misconduct in a separate letter to PacificSource Administrators and attach to this form.

Step 3: **Current Benefits**

Health

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

Dental

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

Vision

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

Flexible Spending Account

*Annual Election Amount $
*Benefit Last Date of Coverage
*Plan Year Start Date
*Plan Year End Date

Other Health Plan

*Plan Name
*Carrier Name
*Coverage Level
*Last Date of Coverage

Severance Enter the amount (flat rate or percentage) to be applied to the QB's monthly premium.

	Amount	Start Date	End Date
Medical			
Dental			
Vision			

Step 4: **Other Covered Family Members**

*Spouse Name (First, Middle Initial, Last)

*Date of Birth (mm/dd/yyyy)

*Social Security Number

Mailing Address (If different from above)

City

State

Zip

*Dependent(s) Name	*Relationship (ex. child)	*Social Security Number	*Date of Birth

Step 5: **Employer Authorization**

I hereby certify that the information contained above is accurate to the best of my knowledge. I understand that PacificSource Administrators will not be held liable for missing or inaccurate information.

*Completed By:

*Daytime Phone Number

*Date: