SCHEDULE B - COMPLETE THE FOLLOWING FOR EACH COBRA / DIRECT BILLING PLAN SPONSORED (Health, Medical, Dental, Vision, HRA, FSA, etc.)
PLEASE MAKE ADDITIONAL COPIES OF THE FORM AS NEEDED

Questions?? Contact gente Employee Benefits and HR Solutions Strong relationships start here ***at (973)995-1000 or cobra@gente.solutions***

_____
Carrier Name

_____ *(Medical, Dental, Vision, FSA, EAP, Life, Etc.)*
Insurance Type

_____ *(HMO, PPO, POS, DMO, Etc.)*
Plan Name *(must be unique across all employer sponsored plans and used for all correspondence)*

_____ Fully Insured **YES** **NO**
Plan Policy # Next Plan Anniversary Date

_____
Cust. Srvc. Contact Phone Fax Email

_____
Enrollment Contact Phone Fax Email

_____
Enrollment Address Street City ST Zip+4

Is this plan available to a specific division? **YES** ○ **NO** ○ Division Name: _____

Coverage Termination *(circle one)* **Event** ○ **End of Month** ○ **Wash/Roll** ○

Does This Plan Offer Conversion? **YES** ○ **NO** ○ Is this plan available only to Direct Bill Members? **YES** ○ **NO** ○

Do you charge 50% premium surcharge during disability extensions under COBRA? **YES** ○ **NO** ○

Plan Rate Type (*circle one*) **Composite** ○ **Age/Gender Based** *(include copy of rate table)* ○

If plan rates are **Age/Gender based**, does the carrier adjust the Member's premium on their **birth date** or at the **plan anniversary**?

Birthday ○ **Plan Anniversary** (*Circle one*) ○

Composite Rate Table (complete all that apply)

Coverage Level	Monthly Premium (without 2%)	Units Based Rates
Employee Only		
Employee + Spouse		
Employee + Child		
Employee + Children		
Employee + Family		
Employee + 1 dependent		
Employee + 2 dependents		
Spouse Only		
Spouse + Child		
Spouse + Children		
Child Only		

Comments / Special Instructions