GBS
Group Benefit Services

INFORMATION FOR GBS ADMINISTRATION OF EXTENDED BENEFITS

SECTION 1 – GROUP INFORMATION

COMPANY NAME: _____

GBS ACCOUNT NUMBER (IF EXISTING GBS ACCOUNT): _____

REQUESTED EFFECTIVE DATE OF ADMINISTRATION: _____

SECTION 2 – EMPLOYEE INFORMATION-REQUIRED

Administration of extended benefits is based upon the total number of full-time and part-time employees in your company for 50% of the typical business days in the previous calendar year regardless of whether they are currently enrolled in your group benefit program. Each part time employee counts as a fraction of an employee, with the fraction equal to the number of hours the part time employee worked divided by the hours an employee must work to be considered full time. Example: If full time = 40 hours, an employee working 20 hours is counted as ½ an employee. (20 divided by 40)

- **Federal COBRA** applies to groups with 20 or more employees.
- **State Extension** applies to groups with fewer than 20 employees.

Indicate the total number of employees in your company (as defined above): _____

SECTION 3 – EMPLOYEES/DEPENDENTS REQUIRING NOTIFICATION

Please complete the information below for any recently terminated employees or dependents for which you are requesting GBS send notices to offer extended coverage. If none, please indicate "NONE". GBS will not issue notices to employees terminated prior to our administration effective date.

Employee/Dependent Name	Street Address	City	State	Zip	Coverage Termination Date

SECTION 4 – EXISTING EMPLOYEES/DEPENDENTS ON EXTENSION

Please complete the following information for any employee or dependent currently being billed for extended coverage. If none, please indicate "NONE". GBS will begin billing members directly as of the date group enrolls with GBS/date confirmed based on our review of existing account.

Employee/Dependent Name	Social Security Number	Original Termination Date	Length of Extension	Last Paid Month

I have reviewed the outline of responsibilities for Cobra/ State Extension services through Group Benefit Services, Inc. I understand that I retain liability for the Employer Responsibilities as outlined on the document.
I hereby verify that all information provided above is correct.

_____ _____ _____
Company Official Signature **Title** **Date**

_____ _____ _____
Print Name **( ) Phone #** **( ) Fax #**