



MONGOOSE®

RATE RENEWAL REQUEST



Please mail, fax, or email to:

AMERIFLEX
700 East Gate Drive, Suite 510
Mount Laurel, NJ 08054
Attn: COBRA Department
E-mail: COBRA@flex125.com
Phone: 888-868-3539
Fax: 609.257.0136

▶ In order to keep your COBRA plan and participants in compliance, AmeriFlex requests Carrier Rate Renewal information at least 30 days prior to your new plan year. Please complete the following for each sponsored COBRA/Direct Billing Plan.

Company Name _____
Contact for Renewal Questions: _____
Current Number of Benefit Eligible Employees: _____

Broker/Agent Information *(only required if information has changed)*

Agency Name: _____ Broker Name: _____
Address: _____
Phone: _____ Email: _____

Plan Information: _____

Carrier Name: _____ Insurance Type: _____
(Medical, Dental, Vision, EAP, etc.)
Plan Name: _____
(HMO, PPO, POS, DMO, etc.) NOTE: Must be unique across all employer sponsored plans and used for all correspondence.

Plan Policy Number: _____ Next Plan Anniversary Date: _____ Fully Insured? YES NO
Cust. Srv. Contact: _____ Phone: _____ Fax: _____ Email: _____
Enrollment Contact: _____ Phone: _____ Fax: _____ Email: _____
Enrollment Address: _____

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

Coverage Termination: Date of Qualifying Event End of Month Wash/Roll

Does this Plan offer Conversion? YES NO

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

Plan Rate Type: 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 Plan Anniversary

Composite Rate Table

(complete all that apply)

Coverage Level	Monthly Premium <small>(without 2%)</small>
Employee Only	_____
Employee + Spouse	_____
Employee + Child	_____
Employee + Children	_____
Employee + Family	_____
Employee + 1 dependent	_____
Employee + 2 dependents	_____
Spouse Only	_____
Spouse + Child	_____
Spouse + Children	_____
Child Only	_____