Form 100

NOTICE TO COMPANY OF PREMIUM RATES

Please submit one form for each plan

TO: Via Fax (724) 514-6648
Via E-Mail
linda.rall@hracobra.com or alena.loiselle@hracobra.com or sandra.stankus@hracobra.com

Human Resources America, Inc.
P.O. Box 8
Houston, PA 15342

FROM: _____ ("Client") DATE: _____

_____ Contact name

_____ Contact Telephone

PREMIUM RATES

As of _____, the applicable premium under _____ (the "Plan") shall be as follows:
Name of Insurance Company_____

Address_____

_____

Customer Service Telephone _____

(Circle one:) Medical Dental Vision Prescription

Individual_____

Family _____

Individual + 1_____

Individual + Spouse_____

Individual + Child_____

Individual + Children_____

Other (please specify)_____

Contract Year beginning date _____ to _____.
Can this be converted to an individual policy after Cobra term? Yes No
Age dependents become ineligible ( ) Full time Student ( )
Date coverage terminates - Last day of employment ( ) End of the month ( )