



**CBIA Service Corporation (CBIASC)  
for administration of  
Federal COBRA or Connecticut Continuation Services**

**Employers with 20 or more employees**

- Federal COBRA (COBRA)
- CBIA Level Funded Medical – 18 months continuation
- All dental and vision plans – 18 months continuation

**Employers with 19 and fewer employees**

- Connecticut Continuation (state continuation)
- CBIA Level Funded Medical - 18 months continuation by employer choice
- All dental and vision plans – 18 months continuation

To activate this service please read the contract, sign the agreement and return to:

CBIA Insurance Administration  
350 Church Street Hartford, CT 06103-1126  
hcservice@cbia.com or fax to 860.278.0883

If you have former employees and/or dependents currently on continuation, complete and return the Continuant Takeover Form included in this packet.

**CBIA Service Corporation  
Federal COBRA or Connecticut Continuation  
Service Agreement Signature Page**

**Please complete, sign and return this page to CBIA Insurance Administration. 350 Church Street, Hartford, CT 06103-1126, fax to: 860.278.0883, or email to [hcservice@cbia.com](mailto:hcservice@cbia.com).**

I have read this Agreement and agree to the terms and conditions herein.

CLIENT NAME: \_\_\_\_\_

CLIENT ADDRESS: \_\_\_\_\_

Signed by: \_\_\_\_\_

Name: \_\_\_\_\_  
(Print)

Title: \_\_\_\_\_  
(Print)

Date of Signature: \_\_\_\_\_

Client's Requested Date for CBIASC to start Services: \_\_\_\_\_

\_\_\_ I do not have any existing COBRA or State Continuation continuants.

\_\_\_ I do have existing COBRA or State Continuation continuants, who I am transferring to CBIASC for Services through the attached Continuant Takeover Form. (See Appendix A)

\_\_\_ Group size for continuation

CBIA SERVICE CORP., INC.  
350 Church Street  
Hartford, CT 06103-1126

\_\_\_\_\_  
Matthew Howe  
Senior Vice President

EFFECTIVE DATE: \_\_\_\_\_

**CBIA Service Corporation  
Federal COBRA or Connecticut Continuation  
Service Agreement**

AGREEMENT dated \_\_\_\_\_, between \_\_\_\_\_ (“Client”) with offices at \_\_\_\_\_, and CBIA SERVICE CORP., Inc., (“CBIASC”), with offices located at 350 Church Street, Hartford, CT 06103. Without notice of cancellation, this Service Agreement is automatically renewed for a twelve (12) month period.

In consideration of the mutual promises contained herein, Client and CBIASC agree as follows:

**I. SERVICES and RESPONSIBILITIES.**

**A. CBIASC SERVICES**

1. Client (for itself and on behalf of its plan administrator) hereby retains CBIASC to provide, and CBIASC hereby agrees to provide, the following non-discretionary, ministerial record-keeping and notification services (the “Services”) as described below:
  - a. Creation and mailing of initial COBRA or State Continuation notification to Client’s employees and dependents when they first become eligible for coverage through Client’s health and/or dental plan(s) offered through CBIASC.
  - b. Creation and mailing of COBRA or State Continuation notice and election form to Qualified Beneficiaries (QBs), as defined in Section II. A., immediately following a Qualifying Event, as defined in Section II. B., herein.
  - c. Enrollment in COBRA/State Continuation of Coverage benefits of QBs who elect COBRA/State Continuation-of-Coverage.
  - d. Creation and mailing of monthly premium bills to COBRA or State Continuation enrollees (“Enrollees”).
  - e. Provision of telephone information and support regarding eligibility, enrollment and billing to QBs and Enrollees.
  - f. Notification to Enrollees of the termination of COBRA or State Continuation benefits.
  - g. Notification to Enrollees of renewal, changes or termination of Client’s continuation-eligible benefits.
  - h. Transmission of premiums received from Enrollees to health and/or dental insurance carriers.
  - i. Communication of QB enrollment and disenrollment to health and/or dental insurance carriers.
2. CBIASC shall not be required to provide the Services herein enumerated until the Effective Date, which shall be the Effective Date designated by CBIASC on the Signature Page of this Agreement. In no case shall the

Effective Date designated by CBIASC be sooner than the date the Client signs and returns the Signature Page of this Agreement to CBIASC at the address shown.

## B. CLIENT RESPONSIBILITIES

1. CBIASC COBRA or State Continuation Services require Client to perform, and Client agrees to perform, the following responsibilities:
  - a. Make available to COBRA or State Continuation Enrollees the same health and dental options as are available to Client's current employees and dependents.
  - b. Complete and return to CBIASC the Continuant Takeover Form (Appendix A) for any existing COBRA or State Continuation continuants.
  - c. Notify CBIASC when employees or dependents first become eligible for coverage under Client's health and/or dental plan, within 31 days of the effective date of coverage under the plan(s).
  - d. Notify CBIASC when employees or dependents experience a COBRA or State Continuation Qualifying Event as defined in Section II, by completing and mailing to CBIASC a Qualifying Event Form (Appendix B) within 14 days of the Qualifying Event effective date.
  - e. Notify CBIASC of any changes in, or termination of, Client's health and/or dental plan(s) within 15 days of the change or termination.
  - f. Notify CBIASC in the event of any sale, transfer, merger or acquisition of Client's business, or if Client files for federal bankruptcy.
2. Client understands that as a condition of CBIASC providing the Services enumerated in Subsection A., Client shall timely and accurately perform all of the enumerated Responsibilities and provide the information required in this Agreement and any amendments thereto. CBIASC reserves the right to request additional information from Client at any time. CBIASC shall be entitled to rely on any information provided by the Client as accurate, valid and complete.

## C. AMENDMENTS TO SERVICES AND RESPONSIBILITIES

CBIASC and Client understand that the Services and Responsibilities herein enumerated are requirements and procedures dictated by federal COBRA and State Continuation laws. If the requirements and procedures are changed by law, CBIASC will amend this Agreement to incorporate the changes in the law and provide such amendments ("Amendments") to the Client. Client will be deemed to have accepted and approved each Amendment thereto if Client does not promptly notify CBIASC in writing that it objects to any provision of the Amendment thereto.

## II. DEFINITIONS

- A. **Qualified Beneficiary (QB)** – The employee and/or dependent(s) who are covered under an employer health and/or dental plan on the day before a Qualifying Event.
- B. **Qualifying Event (QE)** – Any of the occurrences listed below, which cause an employee and/or dependent(s) who are covered under an employer health and/or dental plan to be disqualified from group coverage, are Qualifying Events. Client agrees to notify CBIASC whenever any of Client's employees or dependents

experience any one of the following Qualifying Events by completing and mailing a Qualifying Event Form (Appendix B) to CBIASC within 14 days of the Qualifying Event:

1. An employee terminates employment for any reason (other than, in certain circumstances, for gross misconduct), including voluntary termination.
2. An employee experiences a reduction of work hours, including work stoppage and non-FMLA leave-of-absence.
3. An employee and spouse experience a divorce or legal separation, disqualifying the spouse from dependent coverage.
4. A child ceases to qualify for dependent coverage because the child:
  - reaches age 26; or
  - has an offer of coverage from their employer
5. A dependent ceases to qualify for dependent coverage because an employee becomes entitled to Medicare.
6. If the Client declares bankruptcy under Chapter 11, this is a qualifying event to any retirees (and their dependents) who are covered by the Client's continuation-eligible benefits.

NOTE: In addition, if a dependent Enrollee experiences a second Qualifying Event, the dependent may be eligible for a total of 36 months of COBRA or State Continuation measured from the date of the first Qualifying Event.

### **III. DISCLAIMER.**

- A. CLIENT ACKNOWLEDGES THAT THE PERFORMANCE OF SERVICES BY CBIASC DOES NOT AND IS NOT INTENDED TO MAKE CBIASC THE "PLAN ADMINISTRATOR," "PLAN SPONSOR," OR OTHER "FIDUCIARY" UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974, AS AMENDED, OR OTHERWISE OF ANY PLAN, AND CLIENT WILL NOT IDENTIFY OR REFER TO CBIASC OR ANY OF ITS AFFILIATES AS SUCH. CBIASC HAS NO DISCRETIONARY AUTHORITY OR DISCRETIONARY RESPONSIBILITY IN THE ADMINISTRATION OF THE CLIENT'S HEALTH AND/OR DENTAL PLAN(S). The parties further acknowledge and agree that CBIASC will not be deemed to be providing legal or tax advice to Client as a result of the ministerial duties undertaken by CBIASC pursuant to this Agreement.
- B. Client shall not use CBIASC's or its affiliates' names or marks without CBIASC's prior written consent.

### **IV. FEES, TAXES, PAYMENTS.**

- A. Client understands and agrees that CBIASC will bill the QB who CBIASC enrolls for COBRA or State Continuation benefits, as follows:
  1. The cost due for coverage; and,
  2. An Administrative Fee computed as 2% of premium, as permitted by state and federal law.

- B. Client acknowledges that CBIASC will retain the Administrative Fee as compensation for Services rendered hereunder.

## **V. LIABILITY AND INDEMNIFICATION.**

- A. CBIASC shall not have any obligation or liability with respect to any Services before the Effective Date of this Agreement, including notices and the collection and remission of premiums.
- B. CBIASC shall not have any obligation to verify or determine the accuracy, validity or completeness of information provided by Client or its plan administrator, and shall not be responsible for errors, delays or additional costs resulting from the receipt of inaccurate, invalid, incomplete or untimely information or information provided in an unacceptable format or media. Client and/or its plan administrator agree to provide any and all information to CBIASC on a timely basis.
- C. In the event of an error in CBIASC's records or any reports or statements prepared by CBIASC and caused by CBIASC, CBIASC shall correct such records, reports or statements, provided that Client advises CBIASC of such error within 30 days of the receipt of such record, report or statement.
- D. CBIASC is not required, under the terms of this Agreement, to review any action of Client or its plan administrator(s). Furthermore, CBIASC will not incur any liability by taking, permitting or omitting any actions on the basis of any action of Client or its plan administrator or for carrying out the directions of Client or its plan administrator.
- E. Client agrees to defend, indemnify and hold harmless CBIASC, its affiliates and their directors, officers, employees, legal representatives, agents, successors, and assigns from and against all claims, losses, liabilities, damages, demands, lawsuits, causes of action, costs and expenses (including reasonable attorneys' fees and costs) (collectively "Losses") as a result of entering into and performing services under this Agreement or any other cause arising out of this Agreement, except to the extent those Losses resulted from the gross negligence, willful misconduct or willful breach of this Agreement by CBIASC in the performance of the Services.
- F. CBIASC agrees to defend, indemnify, and hold harmless the Client and its plan administrator, and its officers, directors, shareholders, employees and agents (collectively the "Client Group") from and against all Losses asserted against or imposed on any member of the Client Group to the extent those Losses resulted from the gross negligence, willful misconduct or willful breach of this Agreement by CBIASC in the performance of the Services; provided, that (i) CBIASC is promptly notified in writing of such suit or cause of action; (ii) CBIASC controls any negotiations or defense and Client assists CBIASC as reasonably required by CBIASC; and (iii) Client takes all reasonable steps to mitigate any potential damages that may result. Notwithstanding the foregoing, CBIASC shall have no obligation under this Section 5.F. to the extent CBIASC is entitled to indemnification from Client pursuant to Section 5.E or CBIASC is otherwise not liable under this Section 5.
- G. IN NO EVENT WILL CBIASC BE RESPONSIBLE FOR SPECIAL, INDIRECT, INCIDENTAL, CONSEQUENTIAL OR OTHER SIMILAR DAMAGES IN CONNECTION WITH THE SERVICES, EVEN IF IT HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.
- H. CBIASC shall not be liable for any delay or failure to perform under this Agreement resulting, directly or indirectly, from strike, fire, war, insurrection, riot, power failure or a circumstance beyond CBIASC's reasonable control. In case of errors or lost data caused by power failure, mechanical difficulties with information storage and retrieval systems, or other events not attributable to its own negligence or willful

misconduct, CBIASC's sole obligation will be to use its reasonable efforts to reconstruct any records maintained by CBIASC and to amend any reports prepared by it which may have been affected by such event, at its own expense.

- I. This Section 5 sets forth the full extent of CBIASC's liability hereunder for any claim against CBIASC, and sets forth Client's sole remedies.

## **VI. TERM AND TERMINATION.**

- A. Either party may terminate this Agreement with 90 days prior written notice (or such earlier date as mutually agreed upon between the parties).
- B. Notwithstanding anything contained herein, if Client defaults in the performance of its obligations hereunder (including failure to follow the Client Responsibilities herein enumerated), CBIASC may, upon written notice thereof, terminate this Agreement.
- C. This Agreement shall automatically be terminated in the event Client ceases to be:
  - 1. A participating employer in a health or dental plan sponsored through the CBIA Health Connections Program or CBIA Program; and,
  - 2. A CBIA member in good standing.
- D. This Agreement shall automatically be terminated in the event Client objects to any amendment thereto.
- E. Except as hereinafter provided, the termination of this Agreement shall not affect obligations arising prior to the termination of this Agreement.
- F. Upon termination of this Agreement, CBIASC shall have no further duties or responsibilities with respect to COBRA or State Continuation requirements related to the Client's employees, dependents or COBRA or State Continuation continuants, except CBIASC shall provide for a reasonable transfer of records from CBIASC to Client or its designee upon payment of a reasonable administrative fee, if any.

## **VII. CONFIDENTIALITY.**

- A. For purposes of this Section, "Confidential Information" shall mean: all information of a confidential or proprietary nature provided by the disclosing party to the receiving party for use in connection with the Services, but does not include (i) information that is already known by the receiving party without an obligation of confidentiality; (ii) information that becomes generally available to the public other than as a result of disclosure by the receiving party in violation of this Agreement; and (iii) information that becomes known to the receiving party from a source other than the disclosing party on a non-confidential basis. Confidential Information of CBIASC also includes all trade secrets, processes, proprietary data, information or documentation related thereto of CBIASC or its affiliates and any pricing or product information furnished to Client by CBIASC or its affiliates.
- B. All Confidential Information disclosed hereunder will remain the exclusive and confidential property of the disclosing party. The receiving party will not disclose the Confidential Information of the disclosing party and will use at least the same degree of care in protecting the Confidential Information of the disclosing party as it uses with respect to its own Confidential Information. The receiving party will limit access to

Confidential Information to its employees and advisors with a need to know and will instruct such employees and advisors to keep such information confidential. Notwithstanding the foregoing, the receiving party may disclose Confidential Information to the extent necessary to comply with any law, ruling, regulation or rule applicable to it or to the extent necessary to enforce its rights under this Agreement. In addition, CBIASC may also disclose Client Confidential Information (i) to the extent that disclosure of such information is required to perform the Services, and (ii) in connection with an audit or regulatory examination by a governmental authority.

### **VIII. COMPLIANCE WITH LAWS.**

CBIASC agrees to perform the Services for Client in accordance with a reasonable good faith interpretation of the applicable requirements of federal and state law. Except for such responsibilities assumed by CBIASC pursuant to this Agreement, Client shall be responsible for (i) compliance with all laws and governmental regulations (including state and federal health care continuation laws) affecting Client's business, and (ii) any use it may make of the Services to assist it in complying with such laws and governmental regulations.

### **IX. GENERAL.**

- A. This Agreement shall not be assigned by Client without the prior written consent of CBIASC, and any attempt to assign any rights, duties or obligations which arise under this Agreement without such consent will be void.
- B. Client has not been induced to enter into this Agreement by any representation or warranty not set forth herein. This Agreement contains the entire agreement of the parties with respect to its subject matter and supersedes all existing agreements and all other oral, written or other communications between them concerning its subject matter. This Agreement shall not be modified except by a writing signed by the parties.
- C. Client acknowledges, confirms and agrees that other than CBIASC's obligations to Client hereunder, CBIASC has no obligation to any third party (including any current or former qualified beneficiaries under Client's health and/or dental plan or any agent or other person associated with Client).
- D. Any notice under this Agreement shall be given in writing and hand delivered or mailed to the relevant party. Notices and payments sent by mail shall be deemed to have been mailed on the date of the postmark thereof. Notices shall be deemed received on the date of delivery if delivered in person and five business days after mailing if mailed. Any notice provided through an electronic medium shall be recognized to the extent provided in applicable law to the extent such notice is properly and timely transmitted.
- E. This Agreement shall be governed by the laws of the State of Connecticut, without regard to conflict of laws provisions.

# TRANSFERRING CURRENT COBRA/ STATE CONTINUANTS TO CBIA Federal COBRA or State Continuation Services

Serviced by Vimly Benefit Solutions Inc. (VBS)

This form is only needed if you have current Federal COBRA or State Continuant to be transferred to CBIA Service Corp. Federal COBRA or State Continuation Services.

One form should be completed for each family unit and sent to:

**CBIA Insurance Administration**

**350 Church Street, Hartford, CT 06103-1126 | Fax: 860-278-0883 | Email: HCSERVICE@cbia.com**

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**SECTION 1:**

Enter your company name.

**SECTION 2:**

Check appropriate box to indicate whether Continuant is an employee or dependent. (Check one box only.)

**SECTION 3:**

Enter the Continuant's complete nine-digit Social Security Number.

**SECTION 4:**

Enter the Continuant's complete name (last, first, middle initial) and complete mailing address (street, city, state, and ZIP Code).

**SECTION 5:**

Enter the Continuant's home phone number, including area code, if available.

**SECTION 6:**

Continuant's date of birth (month, day, year).

**SECTION 7:**

Check appropriate box to indicate Continuant's gender (Male or Female).

**SECTION 8:**

Check appropriate box to indicate marital status of Continuant.

**SECTION 9:**

If the Continuant is a dependent of an employee or former employee, enter employee's complete name (last, first, middle initial), employee's nine-digit Social Security Number and Continuant's relationship to employee.

**SECTION 10:**

Enter the month, day and year of the Qualifying Event.

**SECTION 11:**

Enter the LAST DAY (month, day, year) of the Continuant's pre-Federal COBRA or State Continuation Coverage.

**SECTION 12:**

Check appropriate box (check one box only) to indicate the type of Qualifying Event. "Employee's termination of employment" includes voluntary resignation, involuntary termination (except for termination due to gross misconduct), retirement, layoff, or leave of absence. Employee's reduction in hours includes work stoppage (strike)."

**SECTION 13:**

Indicate coverage by checking the box of the appropriate plan code.

**SECTION 14:**

Check appropriate box (Yes or No) to indicate whether at the time of the termination or reduction in hours, the employee was eligible to receive Social Security income.

**SECTION 15:**

Provide information if the Continuant has dependents covered and indicate whether the individual is a Qualified Beneficiary and was covered under the group health plan at the time of the original Qualifying Event or was born to or placed for adoption with a covered employee during the period of Federal COBRA or State Continuation coverage.

# CBIA Federal COBRA or State Continuation Services

## Continuant Takeover Form

## Appendix A

(To transfer current Federal COBRA or State Continuation continuants to CBIA)

### INSTRUCTIONS: *Please print clearly*

- Fill out just one form per family unit (Qualified Beneficiary and Dependents).
- Please do not use this form to report new Qualifying Events - use the Federal COBRA or State Continuation Qualifying Events Form.
- Please see back side of this form for further instructions.

### COMPLETE THIS FORM AND RETURN IT TO:

CBIA Insurance Administration  
350 Church Street  
Hartford, CT 06103-1126  
Fax: 860.278.0883  
Email: HCSERVICE@cbia.com

**PLEASE CHECK ONE BOX:** ☐ **Original Notice** (If FAXED, do not mail copy) ☐ **Revision...** to a form that was previously sent

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1) From: (Company)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |
| 2) Please be advised that the following is currently on Federal COBRA or State Continuation.<br>(Check one box only) <input type="checkbox"/> Employee <input type="checkbox"/> Dependent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                             |
| 3) Social Security Number of Qualified Beneficiary<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |
| 4a) Name of Federal COBRA or State Continuation Continuant (last, first, mi) (Please print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |
| 4b) Street Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4c) City                                                    |
| 4d) State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4e) ZIP Code                                                |
| 5) Home Phone # (if available)<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6) Date of Birth of Qualified Beneficiary<br>____/____/____ |
| 7) Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                             |
| 8) Marital Status (check one box only):<br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                             |
| 14) At the time of termination or reduction in hours, was the employee eligible to receive Social Security income? <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |
| 9) If the above individual listed in box #4 is a dependent of an employee/ former employee, please complete the following:<br>Employee Name (last, first, mi): _____<br>Employee SSN: _____<br>Dependent's Relationship to Employee: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                             |
| 15) If the Federal COBRA or State Continuation Continuant has dependents covered, please complete the following. (Please print)<br>Dependent Name (first, last, mi): _____<br>Birth Date: Mo. _____ Day _____ Yr. _____<br>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female<br>Social Security Number: _____<br>Relationship to employee: _____ Qualified Beneficiary <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |
| 10) Qualifying Event Date<br>____/____/____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                             |
| 11) Last day of Continuation Coverage (cannot be prior to Qualifying Event Date):<br>____/____/____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                             |
| 12) Qualifying Event that caused loss of coverage (check one):<br><input type="checkbox"/> Employee's termination of employment (includes voluntary resignation, involuntary termination (except when due to gross misconduct), retirement, layoff, or leave of absence)<br><input type="checkbox"/> Employee's reduction in work hours (includes work stoppage or strike)<br><input type="checkbox"/> Death of covered employee/ retiree<br><input type="checkbox"/> Divorce/ legal separation<br><input type="checkbox"/> Covered employee/retiree becomes entitled to Medicare; dependents may elect continuance of identical coverage<br><input type="checkbox"/> Ineligibility of dependent child<br><input type="checkbox"/> Retiree, spouse or child of retiree loses coverage within one year before or after commencement of proceedings under Title 11(bankruptcy) United States Code |                                                             |
| 13) Check the current plan code coverages. CBIA administers only plan code coverage options that are permitted by your plan or carrier (check one box only):<br><input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse<br><input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                             |
| Form completed by:<br>Name: _____<br>Date: ____/____/____<br>Phone: _____ Fax: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                             |

CBIA • 350 Church St., Hartford, CT 06103-1126 • 860.525.2242

Serviced by Vimly Benefit Solutions, Inc. (VBS)

**ADDENDUM**  
**to the**  
**CBIA Service Corporation**  
**Federal COBRA or Connecticut Continuation**  
**Service Agreement**

**Purpose**

This Addendum (“Addendum”) is being furnished by **CBIA Service Corporation, Inc. (“CBIASC”)** to **[Employer Name]** (“Client”) in order to notify Client of certain changes in procedure under the **CBIA Service Corporation Federal COBRA or Connecticut Continuation Service Agreement** between the parties (“Agreement”), and to clarify certain rights and obligations of the parties, as set forth in the Agreement.

Specifically, although Client has engaged CBIASC to perform certain COBRA services and Connecticut continuation coverage services (the “Services”) in connection with Client’s health and/or dental plan(s), the Agreement allows CBIASC to delegate certain obligations under the Agreement to a third party. CBIASC has decided to delegate the performance of COBRA and Connecticut Continuation Administration Services to Vimly Benefit Solutions Inc. (“TPA”), as further described below. CBIASC shall be responsible for TPA’s performance of the Services and continues to be bound by the Agreement. TPA’s contact information is as follows:

Vimly Benefit Solutions Inc.  
COBRA Department  
155 NE 100th Street Suite 510  
Seattle WA 98125  
1-833-468-4659  
COBRA@vimly.com

TPA has established an online portal known as “SIMON®.” Client and other employers will be required to submit information to TPA via the online portal, as further outlined below, and may obtain standard reports and other information via SIMON as well.

In addition to delegating the Services to TPA, CBIASC desires to supplement certain provisions within the Agreement, as set forth in this Addendum, to describe in greater detail the legal requirements imposed on each party under COBRA and Connecticut law, to ensure that each party is aware of its rights and obligations.

All other terms and conditions in the Agreement remain unchanged and in full force and effect. In the event of any conflict between this Addendum and the Agreement, the terms of this Addendum shall prevail.

## I. SERVICES and RESPONSIBILITIES.

### A. TPA SERVICES.

1. CBIASC has delegated certain obligations to the TPA to perform the Services described in Section I.A.1 of the Agreement. Effective as of October, 2024, TPA shall perform such Services, which are summarized as follows
  - **Administration of COBRA Continuation Coverage and Connecticut Continuation Coverage:** Provide COBRA continuation coverage services and Connecticut continuation coverage services, including processing enrollments, terminations, and premium payments for COBRA continuation coverage and Connecticut continuation coverage.
  - **Issuance of Required Notices:** Issue initial COBRA notices, election notices, notices of unavailability of COBRA coverage, notices of change in COBRA premium, notices of premium short by insignificant amount, conversion policy notices, open enrollment notices to COBRA Qualified Beneficiaries or Connecticut Qualified Beneficiaries within applicable regulatory deadlines and provide all Connecticut continuation coverage notices required by law.
  - **Premium Collection and Remittance:** Bill and collect COBRA premium payments and Connecticut continuation coverage premiums from COBRA Qualified Beneficiaries or Connecticut Qualified Beneficiaries and remit applicable amounts to the applicable carrier or plan, as instructed by Client or CBIASC.
  - **Record-Keeping and Reporting:** Maintain accurate records of all COBRA-related and Connecticut continuation coverage-related transactions and provide standard reporting access to Client via SIMON®.
  - **Regulatory Compliance Support:** Monitor and adhere to applicable federal COBRA requirements and Connecticut continuation coverage requirements and provide Client updates or guidance as necessary. TPA COBRA assistance is available M-F 8:30am to 5:00pm excluding holidays.

### 2. CLIENT RESPONSIBILITIES.

1. Client shall continue to be obligated to perform the responsibilities described in Section 2 of the Agreement between the parties is revised as follows:
  - **Timely Notification of Qualifying Events:** Notify TPA via CBIA of any Qualifying Event within thirty (30) days of the qualifying event by submitting relevant information in the SIMON® portal or enrollment form to CBIA.

Qualifying Events include:

- **Termination of employment** (for reasons other than gross misconduct)
  - **Reduction in hours of employment** causing loss of eligibility
  - **Death of the covered employee**
  - **Divorce or legal separation** from the covered employee
  - **Covered employee becomes entitled to Medicare**
  - **Loss of dependent child status** under the terms of the plan
- **Accurate and Current Information:** Provide all relevant information to TPA relating to the plan, including type of coverage, coverage period, carrier information (if applicable), COBRA rates and Connecticut continuation coverage rates, [other]. Maintain and update, in SIMON®, all employee and qualified beneficiary information, including but not limited to names, social security number, current mailing addresses, date and type of qualifying event, contact details, eligibility, coverage, changes in coverage, and any other information reasonably requested by TPA and available to Client. TPA will not be responsible for issues related to incorrect address or contact details. Furthermore, Client will be responsible for reviewing all reports and communications from TPA timely and providing TPA with any corrections needed to ensure the information's accuracy.
  - **Payment of Fees:** Remit all applicable fees associated with COBRA administration and Connecticut continuation coverage administration services as agreed in the Agreement.
  - **Compliance with COBRA Regulations:** Cooperate with the TPA as necessary to ensure all necessary steps are taken to comply with COBRA's requirements and Connecticut's requirements.

## II. DEFINITIONS.

**COBRA Qualified Beneficiary** – Means an individual who is eligible for continuation coverage under COBRA as defined in Treas. Reg. § 54.4980B-3, Q/A-1 (a)(1).

**Connecticut Continuation Qualified Beneficiary** (“Connecticut Qualified Beneficiary”) – The employee and/or depend(s) who are covered under a “health insurance” policy (as defined in C.G.S.A. § 38a-469) on the day before a Qualifying Event.

**Qualifying Event** – Any of the occurrences listed below, which cause an employee and/or dependent(s) who are covered under an employer health and/or dental plan to be disqualified from group coverage, are Qualifying Events. Client agrees to notify CBIA and TPA through update in SIMON® whenever any of Client's employees or dependents experience any one of the following Qualifying Events by completing and mailing a Qualifying Event Form (Appendix B) to CBIA within 14 days of the Qualifying Event:

1. An employee terminates employment for any reason (other than, in certain circumstances, for gross misconduct), including voluntary termination.

2. An employee experiences a reduction of work hours, including work stoppage and non-FMLA leave-of-absence.
3. An employee and spouse experience a divorce or legal separation, disqualifying the spouse from dependent coverage.
4. A child ceases to qualify for dependent coverage because the child:
  - a. Reaches age 26; or
  - b. Has an offer of coverage from their employer.
5. A dependent ceases to qualify for dependent coverage because an employee becomes entitled to Medicare.
6. If the Client declares bankruptcy under Chapter 11, this is a qualifying event to any retirees (and their dependents) who are covered by the Client's continuation-eligible benefits.
7. Death of employee.

Note: Duration of the coverage periods for Qualifying Events may vary between COBRA and Connecticut Continuation Program.

**Second Qualifying Events:** If during the initial coverage period, another Qualifying Event occurs for a spouse or dependent child, they may be eligible for an extension. Under COBRA, this extension adds eighteen (18) months to the typical initial eighteen-month coverage period. Under the Connecticut Continuation Program, the extension adds six (6) months to the initial thirty-month coverage period. The extension, triggered by a second Qualifying Event, can extend the total COBRA or Connecticut Continuation coverage period to a maximum of thirty-six (36) months.

In addition to the extension of coverage relating to a Second Qualifying Event, coverage may also be extended by an additional eleven (11) months coverage, extending the total to twenty-nine (29) months, in the event a COBRA Qualified Beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of coverage.

### **III. DISCLAIMER.**

In addition to the statements in Article III (Disclaimer) in the Agreement, Client acknowledges:

- A. Client shall be the final decision-maker with respect to any disputes, appeals, eligibility determinations, resolution of errors, etc., arising in connection with the administration of COBRA and Connecticut continuation coverage, and that it shall provide TPA with appropriate instructions with respect thereto.
- B. It is expressly understood that TPA is neither the "Plan Administrator" nor a "Named Fiduciary" with respect to the Plan, as defined by ERISA or the Internal Revenue Code as the result of this Agreement. TPA's role as outlined in this Agreement is limited to administrative functions specified herein and does not extend to the management, control, or administration of the Plan assets.

#### **IV. FEES, TAXES, PAYMENTS.**

#### **V. LIABILITY AND INDEMNIFICATION.**

In addition to the terms set forth in the Agreement, Client acknowledges:

- A. Neither CBIA nor TPA shall be liable for any penalties, fines, or legal actions resulting from Client's failure to provide accurate, complete, or timely information regarding COBRA-qualified beneficiaries or qualified beneficiaries under Connecticut continuation coverage laws. Client also acknowledges that it retains ultimate responsibility for COBRA compliance.
- B. Client agrees to indemnify, defend, and hold TPA harmless against any loss, damage, or expense, including penalties and reasonable attorney fees, that TPA may incur or be required to pay as a result of any claim, demand, cause of action, lawsuit or proceeding arising out of or in any way in connection with the services provided under this Agreement resulting from the willful misconduct, negligence, fraud or bad faith of CBIA, its employees, agents, or contractors.
- C. Except as expressly stated in this Agreement, TPA provides COBRA administration services "AS IS" and without any warranty of any kind, either expressed or implied. TPA disclaims all warranties, including but not limited to implied warranties of merchantability, fitness for a particular purpose, and non-infringement. TPA does not warrant that the services will be performed error-free or uninterrupted, or that TPA will correct all service errors. Client acknowledges that TPA does not control the transfer of data over communications facilities, including the internet, and that the services may be subject to limitations, delays, and other problems inherent in the use of such communications facilities. This section does not affect those rights that cannot be waived or limited under applicable law.

#### **VI. TERM AND TERMINATION.**

This Addendum shall remain in effect for the duration of the Agreement, which itself may be terminated by either party in accordance with the Agreement's termination provisions.

## **VII. TPA Intellectual Property.**

- A. **Ownership of Intellectual Property.** All intellectual property and related material (the "Intellectual Property") that is developed or produced under this Agreement, including but not limited to documents, data, knowledge, processes, software, graphics, videos, text, and any other materials created, designed, or otherwise developed by TPA in connection with the services provided under this Agreement, shall be the sole property of TPA. Client acknowledges that such Intellectual Property is the exclusive property of TPA and further agrees that it shall not claim ownership over any such Intellectual Property.
- B. **Use of Intellectual Property.** Client is granted a non-exclusive, non-transferable, revocable, limited license during the term of this Agreement to use the Intellectual Property provided by TPA solely for the purpose of utilizing the services under this Agreement. This license does not permit the Client to make any modifications, enhancements, derivatives, or adaptations of the Intellectual Property, nor does it allow for the Intellectual Property to be shared with third parties or used for any other purpose without the prior written consent of TPA.
- C. **Protection of Intellectual Property.** Client agrees to take all reasonable steps to protect the Intellectual Property rights of TPA and to prevent any unauthorized use or dissemination thereof. Any unauthorized use, sale, or copying of the Intellectual Property by the Client (or any entity affiliated with the Client) that is directly or indirectly detrimental to TPA or its operations shall be deemed a material breach of this Agreement and will entitle TPA to terminate the Agreement immediately and to seek any applicable remedies under law.
- D. **Notification of Infringements.** If Client becomes aware of any unauthorized use or infringement of the Intellectual Property of TPA by a third party, Client shall immediately notify TPA in writing. Client agrees to assist TPA in any way reasonably requested by TPA to protect and maintain its Intellectual Property rights.