Benecom Company
Third Party Administrators
3429 Stony Spring Circle
Louisville, KY 40220
(502)499-2501 ◆ (888)739-8587
Fax (502)495-6825 ◆ Email: JNK4466@aol.com

Benefit Summary Sheet

Carrier Information

Name of Insurance Carrier: _____

Insurance Company Contact Name: _____ Email: _____

Address: _____ City, State, Zip _____

Telephone: ( ) _____ Fax: ( ) _____

Plan Information

Plan Name: _____

Group # _____

Effective Date: _____ **Renewal Date:** _____

Plan Type:

☐ Medical ☐ Vision ☐ Dental ☐ FSA

Hour Requirement:

☐ Full Time ☐ Part Time

Eligible for benefit:

☐ 1st day of the month following _____ days ☐ No Waiting Period

☐ 1st day of the month following _____ months ☐ Other _____

Loss of Coverage:

☐ Last Day of Employment Prorate premium ☐ Yes ☐ No

☐ End of the Month ☐ End of Week

☐ Other _____

Loss of Dependant Status: Occurs at age _____. If full time student at age _____.

Maximum Age to Enroll in Plan: Occurs at age _____

☐ 4 Tier	Monthly Premium	☐ 3 Tier	Monthly Premium	☐ 2 Tier	Monthly Premium
Employee Only	_____	Employee Only	_____	Employee Only	_____
Employee + Spouse	_____	Employee + One	_____	Employee + One	_____
Employee + Child(ren)	_____	Family	_____		
Family	_____				

Are current COBRA participants being charged 102% of the full premium amount? ☐ YES ☐ NO

Does the plan provide for Domestic partners? ☐ YES ☐ NO

Is Conversion Available for this plan? ☐ YES ☐ NO