ELECTION NOTICE AND FORM FOR WISCONSIN CONTINUATION COVERAGE

To: _____ Date: _____

Covered Employee's or Former Employee's Name: _____

Under Wisconsin law, the following eligible individuals who lose group medical coverage due to a "qualifying event" may continue to be covered for medical benefits under the **Welfare Benefit Plan of _____ (Insert Employer's Name)** (the Plan) through the Wisconsin Bankers Association Insurance Trust Fund (the Trust). No Wisconsin continuation coverage is available for dental or vision coverage. Contact information for the Employer sponsor of your Plan is provided at the end of this notice. You should also read the State of Wisconsin Fact Sheet on continuation coverage. **Please note that if your Employer has 20 or more employees as defined under federal regulations, you may also be eligible for federal COBRA continuation coverage. Please check with your Employer.**

ELIGIBLE INDIVIDUALS

To qualify for continuation coverage, the following categories of eligible individuals must have been covered by the Plan for at least 3 consecutive months before the qualifying event occurred.

An employee member who voluntarily or involuntarily loses eligibility for coverage under the Plan, other than if loss of coverage is because of termination of employment due to discharge for misconduct. (The group member may cover a spouse and dependent children if they were covered immediately prior to loss of coverage);

The surviving spouse or dependent child of a group member who dies while covered by the Plan if the surviving spouse and/or dependent child also were covered; or

The former spouse of a group member who would otherwise lose coverage because of divorce or annulment;

Please note that only the employee group member has the right to elect Wisconsin continuation coverage unless the employee group member is deceased or, in the case of a former spouse, when there is a divorce or annulment. The employee group member elects Wisconsin continuation coverage for all family members who were covered prior to the qualifying event.

NOTICE AND ELECTION REQUIREMENTS

If a family member would lose coverage because of a divorce, annulment or death of a group member, it is the responsibility of the person(s) who would lose coverage due to these "qualifying events" to notify the Employer. When a qualifying event occurs, the Employer will notify the eligible individuals as defined above of their rights to continue coverage. Eligible individuals as defined above then have 30 days from the date they would otherwise lose coverage to elect continuation coverage. As noted above, the employee group member elects continuation coverage for all family members who were covered on the day before the qualifying event. If an eligible individual as defined above does not elect coverage on a timely basis, coverage under the Plan will not be continued past the date it would otherwise have ended.

COST OF COVERAGE

The cost of continued coverage is paid entirely by the eligible individual who elects such coverage. Rates are established each year and are subject to change.

LENGTH OF COVERAGE

Coverage can be continued for up to 18 months from the date coverage would otherwise end due to the qualifying event. Coverage will be terminated before the end of the maximum period when the earliest of the following occurs:

1. The date the group policy terminates or termination of the employer's group medical plan for any employee;

2. The date you fail to make timely premium payment;
3. The date a person who is continuing coverage becomes eligible for similar coverage under another group policy;
4. The date a person who is continuing coverage establishes residence outside Wisconsin;
5. In the case of an ex-spouse who is continuing coverage because of divorce or annulment, the date the former spouse who is the employee loses eligibility under the Plan; or
6. 18 months from the date group insurance coverage would otherwise have terminated due to loss of eligibility.

OTHER OPTIONS

Instead of enrolling in Wisconsin continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than Wisconsin continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Your Employer will provide a separate notice regarding federal COBRA continuation coverage if such coverage is applicable to your Employer.

Questions should be directed to:

Employer Name: _____

Human Resources Department

Address: _____

_____

_____

_____

WISCONSIN CONTINUATION COVERAGE ELECTION FORM

To: _____ Date: _____

Covered Employee's or Former Employee's Name: _____

Notification of Rights to Continue Group Medical Coverage under Wisconsin Statutes

Your coverage under your Employer's group medical insurance plan under the **Welfare Benefit Plan of _____ (Insert Employer's Name)** (the Plan) through the Wisconsin Bankers Association Insurance Trust Fund (the Trust) terminates as of _____, 20___. However, under Wisconsin law, you may be eligible to elect to temporarily continue coverage under the Plan beyond this date, You do not have to show that you are insurable (in good health) to elect "continuation coverage." You may have separate rights to continuation coverage under federal law. Refer to the Plan Booklet.

Wisconsin statutes require only that you be offered an opportunity to elect to continue group medical coverage. The law does not apply to any dental or vision coverage. Continuation coverage may not cover expenses covered by Medicare.

Please read the Election Notice for Wisconsin Continuation Coverage which is attached to this Election Form.

Election of Wisconsin Continuation Coverage

You will have no coverage beyond _____, 20 ___ until you timely elect continuation coverage.

To be eligible for continuation coverage under Wisconsin law, you must elect continuation coverage on this Election Form and remit your first premium payment to your Employer **within 30 days after receiving this notice**. If an eligible individual as defined in the attached Election Notice does not elect coverage on a timely basis, Plan coverage will not be continued past the date it would otherwise have ended as designated above.

Eligible Individuals

If you are currently enrolled for family coverage, your election to continue medical coverage under Wisconsin law will be for family coverage.

Our records show you are enrolled in: ☐ single coverage ☐ family coverage

The following person named in the categories below is entitled to elect Wisconsin continuation coverage for medical coverage under the Plan for up to 18 months:

Eligible Individuals	**Does the named individual have Medicare or Other Group Coverage?**
☐ Employee or former employee Name: _____ (Elects for all family members who were covered prior to the event that caused a loss of Plan coverage Names of Other Family Members: _____ _____ _____ _____	☐ Yes ☐ No If yes, please explain: _____ _____ _____

Eligible Individuals	Does the named individual have Medicare or Other Group Coverage?
☐ Surviving spouse covered under the Plan on the day before Plan coverage was lost due to the employee's death Name: _____	☐ Yes ☐ No If yes, please explain: _____
☐ Dependent children covered under the Plan on the day before Plan coverage was lost due to the employee's death *(list by name if possible or by status)* Name(s): _____	☐ Yes ☐ No If yes, please explain: _____
☐ Former spouse covered under the Plan on the day before the event that caused the loss of Plan coverage due to divorce or annulment Name: _____	☐ Yes ☐ No If yes, please explain: _____

PREMIUM PAYMENTS (INCLUDING AUTHORIZED ELECTRONIC PAYMENTS) FOR CONTINUATION COVERAGE

The monthly premium to continue coverage is shown below. Premiums are subject to change but will not exceed 100% of the applicable group rate as long as you are eligible for continuation coverage under Wisconsin law. (The applicable group rate includes the amount we may have previously contributed.) We will notify you of any change in premiums.

If you timely elect continuation coverage, coverage will be retroactive to the date your group coverage terminates under the Plan. The first premium will cover the period beginning _____, 20 ___ [date your coverage terminates under the Plan] and ending on _____, 20 ___. It is due within 30 days after you receive this notice. Make your premium payment payable to your Employer.

Subsequent premiums are due on the first day of each month for which coverage is in effect. Failure to make timely payment results in automatic termination of coverage. Any check that is returned for insufficient funds or a rejected electronic transfer of funds will be considered non-payment.

Current Monthly Rates Are:

$_____ Single Medical Coverage $_____ Family Medical Coverage*

Initial Premium for Wisconsin Continuation Coverage from: _____

$_____ Single Medical Coverage $_____ Family Medical Coverage*

* *Family Medical Coverage includes Employee + Spouse, Employee + Spouse + Dependent Children or Employee + Dependent Child(ren), depending on your enrollment on the day before the qualifying event.*

The premium payments must be sent or electronically transferred to your Employer at the address provided at the end of this Election Form.

ELECTION

Please make your election below.

Check one:

- ❑ I do **not** elect to continue medical coverage under Wisconsin law
- ❑ I elect to continue medical coverage under Wisconsin law for the eligible individuals as designated on this Election Form.

I have read and understand the attached Election Notice on Wisconsin continuation coverage.

Signature	Date
Print Name	Relationship to individual(s) listed above
	Telephone number
Print Address	

Please return this Election Form and your first month premium (if you elect coverage) by check or electronically to your Employer within 30 days after you receive this notice by _____, 20 _____ by mail, fax (if your Employer fax number is displayed below) or hand delivery. Failure to respond within the 30 day time period allowed indicates that you are not interested in continuing your medical coverage under Wisconsin law. However, we also ask that you return the Election Form to your Employer whether you elect or decline coverage. Please keep a copy of the Election Form for your records.

This Notice and Election Form do not summarize federal law which also may apply. Your Employer will provide a separate notice regarding federal continuation under COBRA if federal COBRA continuation coverage is applicable to your Employer.

QUESTIONS

If you have any questions, contact:

Employer: _____

Name of Employer Contact: _____

Address: _____

Telephone: _____

Fax: _____