Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

(Employer must check one prior to giving to the qualified beneficiary.)

☐ You are NOT eligible for continuation (COBRA) coverage. Please refer to Item 1 of the attached notice for the reason you are not eligible.

☐ You are eligible for continuation (COBRA) coverage. Your health insurance coverage through the employer will end on the date indicated in the Employer Section — Item 2 of the attached notice — unless the Department of Employee Trust Funds (ETF) receives the attached notice postmarked within 60 days of the date of the employer's signature in Item 8 or within 60 days of the date your coverage ends (Item 2), whichever is later. Please read instructions below.

INSTRUCTIONS FOR ELECTING CONTINUATION (COBRA) COVERAGE

1. **If applying for COBRA, check box A (COBRA election) on the attached *Continuation-Conversion Notice*; date and sign the notice.**
2. **If applying for COBRA while your DISABILITY APPLICATION is pending, check box B on the attached Continuation-Conversion Notice; date and sign the notice.**
3. **Complete the enclosed health insurance application unless you are the employee and will be continuing the coverage in effect with no changes. If a health insurance application was not included, please contact the subscriber's former employer or go online at http://etf.wi.gov/publications/et2301.pdf and print one. If anyone covered under this policy is enrolled in Medicare, you must include a copy of the Medicare ID card.**
4. **Send this notice and the health insurance application form, if required, to ETF. A copy of this notice will be returned to you as an acknowledgment and per federal COBRA Law, the health plan will notify you of the due date for premium payments, the address to which payments should be sent, and the grace period for payment. You have the right to pay premium on a monthly basis, in which case your health plan will bill you directly.**
5. **CANCELING COBRA COVERAGE — After applying for coverage, if you wish to discontinue coverage, you must submit your request to cancel coverage in writing to ETF.** Coverage ends at the end of the month following receipt of your written request to ETF. If when you apply for coverage you know you will want to cancel coverage after only one or two months, you can submit a written request to cancel coverage that identifies a specific date for coverage to end along with your application for coverage. Remember, once a request to cancel coverage has gone into effect, coverage cannot be reinstated.

GENERAL INFORMATION

A & B. COBRA — Coverage under the group health insurance program will end for you and all qualified beneficiaries (QBs) on the date entered in Item 2 of the attached notice. A QB is any person losing coverage who was covered on the date of the qualifying event entered in Item 4 of the attached notice. Under federal law, known as COBRA, you and your QBs may continue this coverage. The maximum period of continuation coverage for a qualifying event is: 18 months after employee's termination for the employee, spouse, Chapter 40 domestic partner or dependent child; 36 months after employee's divorce/termination of Chapter 40 domestic partnership for the spouse/domestic partner or dependent child; 36 months after employee's death for the spouse/domestic partner or dependent child; and 36 months after the dependent child 's loss of eligibility under the plan. COBRA provides the same coverage you currently have in force. At the end of the COBRA coverage, you may convert to a non-group policy.

In considering whether to elect COBRA coverage, you should take into account that failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

You may elect a different health plan at the time COBRA is elected if you reside in a county that does not include primary providers in the subscriber's health plan. You may change health plans if you move out of the health plan's service area, if your health plan ceases to be offered, or during the annual It's Your Choice enrollment period. Please continue to reference your annual *It's Your Choice* guides for additional information.

COBRA coverage for you and all other QBs will cease and cannot be reinstated on the earliest of the following: 1) the date coverage ceases because premium is not paid timely; 2) the date your former employer no longer offers any group health coverage; 3) the date you and/or any covered QB become covered under another group health plan after the qualifying event on this application.
(Note: If the replacement group health plan has a preexisting conditions limitation, you remain eligible for our COBRA coverage, but only until the creditable coverage to which you are entitled satisfies the preexisting condition limitations of your replacement coverage.)

The employee or the employee's spouse (following divorce) can elect COBRA coverage on behalf of all of the QBs. A parent may elect to continue coverage on behalf of any eligible dependent children. Each QB affected by this notice (that is, who is losing coverage) has an independent right to elect coverage. Contact the employer entered on Item 8 of the notice for information about enrolling for individual coverage(s).

The employer must be notified of loss of coverage within 60 days of the event or your right to continue group coverage is lost, except in the case of divorce.

C. **CONVERSION VERSUS COBRA COVERAGE —** If you wish to convert from group coverage to a non-group policy at this time, check box B, date, sign, and return the notice to ETF. Contact the health plan directly for conversion premium rates. The plan may include a one time conversion access fee. Conversion to a non-group policy may be considerably more expensive and/or provide fewer benefits. You may also have the option to convert to non-group coverage after your continuation coverage period ends. You are responsible for knowing when your group continuation coverage ends, as your health plan does not automatically notify you of termination of coverage. You must contact the health plan directly to apply for conversion coverage. Request for conversion to non-group coverage must be received by the health plan within 30 days after termination of group coverage.

D. **EMPLOYEES WITH 20 YEARS SERVICE WHO ARE ELIGIBLE TO RETIRE —** If you have terminated employment and applied for a retirement annuity from the Wisconsin Retirement System, and your annuity effective date is within 30 days of the date you terminated employment, you may continue coverage for as long as you pay premiums timely. You do not need to complete this form. Premiums will be deducted from your monthly annuity, paid from your accumulated sick leave credits (State only) or by your direct payment to the health plan.

If you have 20 years of creditable service and are eligible for an immediate annuity but are not applying at this time, you may continue coverage by checking box C and returning this form to ETF. Your coverage will continue as long as you make your monthly premiums directly to the health plan. If you are now eligible for Medicare, you must fill out the *Medicare Eligibility Statement* form (ET-4307), available from ETF.

E. **STATE EMPLOYEES WITH 20 YEARS OF SERVICE WHO ARE NOT ELIGIBLE TO RETIRE —** If you are an insured state employee who leaves state service, does not take a separation benefit, and has at least 20* years of creditable service when you terminate employment, and are not eligible for an immediate annuity, you are eligible to continue under the state group health plan for an indefinite period. To continue coverage, check box D and return this form to ETF. You are required to pay the full premiums; you cannot use sick leave credits to pay your premiums. However, your sick leave will be preserved until you are eligible to retire, at which time it will be converted for your use.

*NOTE: In most cases military service is not creditable until retirement. Therefore, military service credit cannot be used to meet the 20-year requirement. Contact ETF if there are questions about creditable service.

OTHER COVERAGE/MEDICARE — Your continuation coverage is affected by other group health insurance coverage that is effective after the qualifying event on this application and Medicare enrollment. You must notify ETF if you become eligible for other group health insurance coverage or Medicare. You are required to enroll in Medicare Parts A and B when first eligible. You are eligible for reduced premiums upon enrollment in Medicare, as long as Medicare is the primary coverage (that is, Medicare pays charges first, then the health plan processes the balance).

This notice does not fully describe continuation coverage or other rights under this plan. More information is available in the *It's Your Choice: Reference Guide*. If you have questions concerning the information in this notice, your rights to coverage or to obtain a copy of the *It's Your Choice* guides, contact the employer entered on Item 8 of the notice or ETF at (608) 266-3285 or toll-free at 1-877-533-5020.

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CONTINUATION – CONVERSION NOTICE

Group Health Insurance
s.2201 of Public Law 99-272

Employee Social Security Number	Member ID
Employee Name (Last, First)	
Employee's Birthdate: (MM/DD/CCYY)	Group #

☐ Employee
☐ Spouse/Former Spouse
☐ Chapter 40 Domestic Partner (DP)/Former DP
☐ Dependent

TO BE COMPLETED BY QUALIFIED BENEFICIARY

Complete and return this notice ONLY if electing to continue or convert coverage.

Read the instructions before completing this notice. It contains important eligibility and other information concerning your rights and responsibilities. After applying for coverage, if you wish to discontinue coverage, you must submit your request to cancel coverage in writing to the Department of Employee Trust Funds (ETF). Coverage ends at the end of the month following receipt of your written request by ETF.

CHECK ONE ONLY - Box A, B, C, D or E. See the instructions for information which corresponds to the following elections.

A ☐ COBRA election: I elect to continue coverage under the group health plan for the allowable maximum period following the date of occurrence listed in Item 4 below. I understand the health plan will bill me directly for premiums at the above address. OR

B ☐ COBRA election while my Disability Application is pending approval, I elect to continue coverage under the group health plan for the allowable maximum period following the date of occurrence listed in Item 4 below. I understand the health plan will bill me directly for premiums at the above address. OR

C ☐ I elect to convert the group coverage to a non-group policy. (Conversion may be considerably more expensive and/or provide fewer benefits.) If electing this option, I understand I am subject to the health plan's conversion policy provisions. OR

D ☐ I have 20 years of creditable service and I am eligible to apply for an immediate annuity but am not applying at this time and want to continue my insurance. OR

E ☐ (For State participants only) I have 20 years of creditable service, and am terminating state employment. (If electing this option, ETF must receive this completed notice by the date shown in Item 2 below.)

DIFFERENT COUNTY/STATE: ☐ I have elected coverage and I live in a county/state that does not have a primary physician in my current health plan. I have indicated on the application form (ET-2301) the health plan to which I am switching.

MEDICARE: ☐ Check here if you or anyone on your policy is eligible for Medicare Parts A & B. (See 3 under "Instruction for Electing Continuation Coverage" and also "Other Coverage/Medicare" on the second page of instructions.)

Date *(MM/DD/CCYY)*	**Signature of Qualified Beneficiary**	**Daytime Telephone** ( )

TO BE COMPLETED BY EMPLOYER PRIOR TO GIVING TO THE QUALIFIED BENEFICIARY

EMPLOYER: Federal law requires this notice to be issued to qualified beneficiaries within 5 days after the date in Item 5. Complete the information above and Items 1-8 below. **Refer to the *Group Health Insurance Employer Administration Manual* for further assistance.**

1. Not eligible for continuation coverage: (Reason) ____________________
2. Date applicant/qualified beneficiary's coverage ends: ____________________
3. Reason for coverage ending (the qualifying event): (check one)
   - ☐ Employment terminated/reduction in hours (18 mos. max. continuation coverage)
   - ☐ Death (36 mos. max. continuation coverage)
   - ☐ Divorce/termination of Chapter 40 domestic partnership (36 mos. max. continuation coverage)
   - ☐ Dependent no longer eligible (36 mos. max. continuation coverage)
   - ☐ Layoff (36 mos. max. continuation coverage)
   - ☐ Other ____________________
4. Date of event in Item 3: ____________________
5. Date employer notified of event in Item 3: ____________________
6. Coverage in effect on date of event in Item 3: ☐ Single ☐ Family

7.	Name of Health Plan		Monthly Premium Rate: Single ☐ Family ☐ $	
8.	Completed By	Date Notice Provided (MM/DD/CCYY)	Employer Name/Number (7-digit)	Telephone ( )

FOR ETF USE ONLY

New Group Number	**Continued Coverage: From (MM/DD/CCYY)**	**Through (MM/DD/CCYY)**	**Telephone 888-681-3952 x1**	
			By	Date **(MM/DD/CCYY)**

Employer: Make a copy for your records and send original to Qualified Beneficiary.