



HEALTH PLAN

We care for Wisconsin.

UNDERWRITTEN BY WPS HEALTH PLAN, INC.

COBRA Notice of Right to Continue Group Health Coverage

Use this form if Employee is electing continuation. If coverage is changing, please attach completed Enrollment form along with this form.

Arise Health Plan P.O. Box 11625 Green Bay, WI 54307-1625 Phone: 920-617-6330 or Toll-Free 1-888-711-1444 Ext. 8330 Fax: 920-490-6928 BillingandEnrollment@wpsic.com

TO: (Eligible Employee or Dependent) Member #: DATE:

Address:

Date of Termination of Group Coverage:

Group Name: Group Number:

Reason for Termination:

In order to retain benefits under the group plan, you will be required to make monthly payments. Your first monthly payment must be received within 45 days of the date of election of continuation of coverage. The first payment is the amount shown below for each month after the date of termination at the top of this notice. Subsequent monthly payments must be received by the first day of each month in the amount and to the address shown below:

Table with 2 columns: Employer's Name and Address, Monthly Payment. Includes a dollar sign and a blank line for the payment amount.

Date: Employer Signature:

Federal law requires that an individual must be offered the opportunity to continue the group health benefits if such individual's coverage would terminate because of:

- 1 The death of the employee;
2 The employee's employment terminates (for reasons other than gross misconduct);
3 The employee's work hours are reduced;
4 The employee's divorce or legal separation;
5 The employee becoming entitled to Medicare;
6 A dependent no longer being a dependent as defined in the group plan.

The continued coverage shall terminate on the earliest of the following:

- 1 18 months (from the qualifying event if) due to 2 or 3 above;
2 29 months (from the qualifying event or within 60 days of the qualifying event if) due to 2 or 3 above and the individual was determined under Title II or XVI of the Social Security Act to have been disabled at the time of 2 or 3 above;
3 36 months (from the first qualifying event if) due to 1, 4, 5 or 6 above;
4 The date the group plan terminates;
5 The individual fails to make timely payment of the required contribution;
6 The individual becomes entitled to Medicare;
7 The individual becomes covered under another group plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such individual.

I DO elect to continue Employee (EE) Family coverage under the group plan, and agree to the conditions and requirements outlined above.
EE & Spouse EE & Child(ren)

I DO NOT elect to continue coverage under the group plan.

I DO elect to convert to an individual plan at this time. Please send me the request for conversion application.

Date: Employee Signature:

You employer must be notified of your election to continue coverage within 60 days of the date you received this notice. You may also convert to an individual conversion plan within 30 days after your group coverage terminates. Please complete this form with your selection indicated and return it to the employer shown above.