



We care for Wisconsin.
UNDERWRITTEN BY WPS HEALTH PLAN, INC.

Wisconsin Notice of Right to Continue
Group Health Coverage

WPS Health Plan, Inc.
P.O. Box 11625
Green Bay, WI 54307-1625
Fax: 920-490-6928
Phone: 920-490-6979

TO: _____ Member #: _____ DATE: _____
(ELIGIBLE EMPLOYEE OR DEPENDENT)

Address: _____

Date of Termination of Group Coverage: _____

Group Name: _____ Group Number: _____

Reason for Termination: _____

Dependent coverage cannot be continued without continuing employee coverage except in the case of the death of the employee. 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 30 days of the date of this notice and 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 payment amount.

Date: _____ Employer Signature: _____

Wisconsin law requires that an individual who has been continuously covered under a plan for at least three months must be offered the opportunity to continue the group health benefits or purchase an individual conversion plan in the event:

- 1 A former spouse's coverage would terminate because of divorce or annulment;
2 An employee's coverage would terminate for reasons other than discharge for misconduct in connection with employment; or
3 Dependent coverage would terminate because of the death of the employee.

Coverage under the group plan continues until the earliest of the following:

- 1 18 months after date of termination (conversion option then available).
2 The individual establishes residence outside of Wisconsin.
3 The individual fails to make timely payment of the required payment amount.
4 In the case of a former spouse, the employee through whom the spouse originally obtained the coverage is no longer eligible for coverage under the plan.
5 The individual is or becomes eligible for similar coverage under another group plan.
6 The date the group plan terminates.

- 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 may convert within 30 days after the termination of your group coverage to an individual health plan (when the option is first made available, during or at the end of the 18 month continuation period). In addition, you are given the opportunity to convert to the individual plan if you move out of the state, or if you are a former spouse and cannot continue in any group plan because the employee is not eligible for any group coverage. Please complete this form with your selection indicated and return it to the employer shown above.