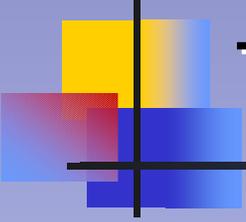


(WPE) Group Health Insurance Training - Part 3

Forms and Monthly Reporting

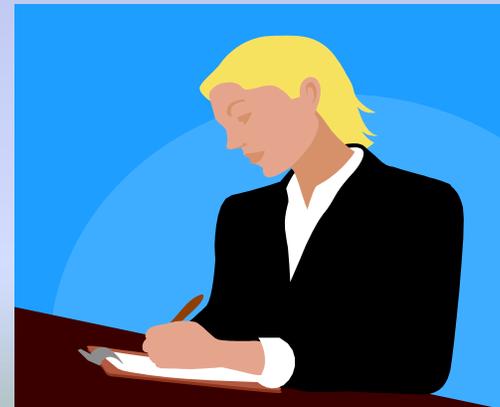


Department of Employee Trust Funds
Mary Pierick, Employer Education Officer



Today's Objective

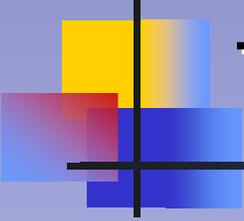
To provide information that will enable you
to administer the health insurance
accurately for your employees



Introduction



- Authorized under:
 - WI Statutes & Administrative Code
 - Group Health Insurance Contract Language
- Administered under the authority of the Group Insurance Board



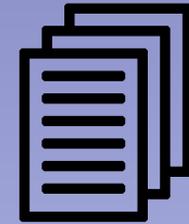
Today's Agenda - Part 3



- Applications and Forms

- 
- Monthly Reporting Background
- 
- 

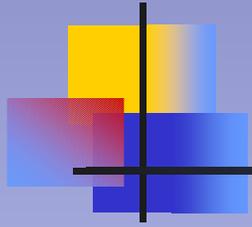
Completing the Forms



"We are what we repeatedly do. Excellence, therefore, is not an act but a habit."

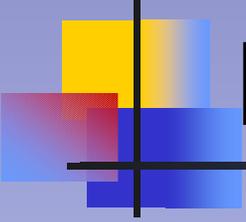
~ Aristotle





Health Insurance Application (ET-2301)

ETF Use Only		State of Wisconsin Department of Employee Trust Funds HEALTH INSURANCE APPLICATION				Employer Notes					
Applicant's Social Security Number			Spouse's/Ex-Spouse's/Dependent of/Survivor of: Name & Social Security Number								
Applicant—Last Name		First	Middle	Maiden Name	NEW HEALTH PLAN SELECTED						
Address—Street and No.			City	State	CURRENT HEALTH PLAN						
Postal Code	County	Country (if not USA)									
ELIGIBILITY STATUS (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant <input type="checkbox"/> Other					I WANT MY COVERAGE TO BE EFFECTIVE: <input type="checkbox"/> As soon as possible <input type="checkbox"/> When employer contributes premium						
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Widowed (date) _____ <input type="checkbox"/> Divorced (date) _____ <input type="checkbox"/> Married (date) _____											
A. REASON FOR SUBMITTING APPLICATION <input type="checkbox"/> Initial Enrollment – 02 <input type="checkbox"/> Dual-Choice - 40 <input type="checkbox"/> LTE/half-time employee elig. for new enrollment period – 02 <input type="checkbox"/> Cancellation – 09 <input type="checkbox"/> Moved from Service Area – 41 Date: _____ <input type="checkbox"/> Transfer from One State Agency to Another - 04 <input type="checkbox"/> Change to Family Coverage – 43 <input type="checkbox"/> Spouse to Spouse Transfer – 31 <input type="checkbox"/> COBRA (or continuation) – 63 <input type="checkbox"/> Change to Single Coverage – 44 or 45* <input type="checkbox"/> Name of State Agency: _____ <input type="checkbox"/> Other: _____											
* The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) up to 36 months. See your Payroll Representative for information.											
B. COVERAGE DESIRED <input type="checkbox"/> Single (Applicant Only) <input type="checkbox"/> Family (Applicant, Eligible Spouse, Eligible Children)											
Last Name		First	Middle	Maiden	Birthdate	Gender	Social Security Number	Rel. Code	Student Status	SELECTED PHYSICIAN OR CLINIC. Indicate 'NONE' if electing Standard Plan.	
Applicant					MO DAY YR	M/F				Name (Last, First)	County
Spouse											
Dependent Children											
Children include: your natural children who are dependent upon you or the other parent for at least 50% of their support and are your natural children, legal wards who became your ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.											
C. OTHER COVERAGE — If you or any family member listed above is covered under other group health insurance, including MEDICARE, list.											
Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes - Covered under Medicare name(s): _____											
HIC# _____ Eff. Date: _____											
Other Coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes Through the State of WI, including University of WI? <input type="checkbox"/> No <input type="checkbox"/> Yes Insurance Company _____											
Name(s) of Insured(s) _____											
Group No. _____ Subscriber (Policy) No. _____ Name of Employer _____											
<input type="checkbox"/> I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the TERMS AND CONDITIONS on the reverse side. A copy of this application is to be considered as valid as the original.										Home Telephone Number ()	
<input type="checkbox"/> I do not wish to enroll at this time, or I wish to cancel my current coverage.										Daytime Telephone ()	
SIGN HERE & Return to Employer →		Applicant Signature					Date Signed (MM/DD/CCYY)				
EMPLOYER COMPLETES AREA BELOW Coding Instructions are in the Employer Health Insurance Manual											
Employer Number		Name of Employer					Program Option Code		Surcharge Code		
69-036-											
Group Number	Enrollment Type	Employee Type	Coverage Type Code	Carrier Suffix	Standard Plan Waiting Period	Participant County Code	Physician County Code				
Previous Service – Complete Information					Date Application Received by Employer (MM/DD/CCYY)		Date Employment Began (MM/DD/CCYY)				
1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No											
2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No											
3. Source of previous service check: <input type="checkbox"/> Extranet <input type="checkbox"/> ETF											
Monthly Employee Share			Monthly Employer Share			Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)			
\$ _____			\$ _____								
Payroll Representative Signature						Telephone		()			



Health Insurance Application

- Employers should:
 - Review applications for completeness
 - Complete Employer section at bottom
 - Send “ETF Advanced Copy” to ETF immediately (1st ply)
 - Send “Carrier Advanced Copy” to carrier immediately (2nd Ply)
 - Keep “Employer Copy” for your records (3rd ply)
 - Attach “Coverage Report Copy” to monthly billing (4th ply)
 - Give “Employee Copy” to employee (5th ply)

Employee Completing The Application

MARITAL STATUS: Single Widowed (date) _____ Divorced (date) _____ Married (date) _____

A. REASON FOR SUBMITTING APPLICATION

Initial Enrollment – 02 Dual-Choice - 40 LTE/half-time employee elig. for new enrollment period – 02
 Cancellation – 09 Moved from Service Area – 41 Date: _____ Transfer from One State Agency to Another - 04
 Change to Family Coverage – 43 Spouse to Spouse Transfer – 31 Name of former State Agency: _____
 Change to Single Coverage – 44 or 45* Name of State Agency: _____ COBRA (or continuation) – 63
 Other: _____

* The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) up to 36 months. See your Payroll Representative for information.

B. COVERAGE DESIRED Single (Applicant Only) Family (Applicant, Eligible Spouse, Eligible Children)

Last Name	First	Middle	Maiden	Birthdate			Gender	Social Security Number	Rel. Code	Student Status	SELECTED PHYSICIAN OR CLINIC.	
				MO	DAY	YR					MF	Indicate "NONE" if electing Standard Plan.
Applicant	★		→				★	★			★	★
Spouse	★								★			
Dependent Children	★								★	★	For all dependents over age 19	

Children include: your natural children who are dependent upon you or the other parent for at least 50% of their support and are your natural children, legal ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

C. OTHER COVERAGE — If you or any family member listed above is covered under other group health insurance, including MEDICARE

Medicare? No Yes - Covered under Medicare name(s): _____
HIC# _____ Eff. Date: _____

Other Coverage? No Yes Through the State of WI, including University of WI? No Yes Insurance Company _____
Name(s) of Insured(s) _____
Group No. _____ Subscriber (Policy) No. _____ Name of Employer _____

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the **TERMS AND CONDITIONS on the reverse side**. A copy of this application is to be considered as valid as the original.

I do not wish to enroll at this time, or I wish to cancel my current coverage.

Home Telephone Number _____



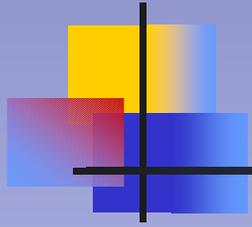
Employer Completing The Application

EMPLOYER COMPLETES AREA BELOW								Coding Instructions are in the Employer Health Insurance Manual	
Employer Number 69-036-	Name of Employer				Program Option Code		Surcharge Code		
Group Number	Enrollment Type	Employee Type	Coverage Type Code	Carrier Suffix ★	Standard Plan Waiting Period	Participant County Code	Physician County Code		
Previous Service – Complete Information 1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Source of previous service check: <input type="checkbox"/> Extranet <input type="checkbox"/> ETF				Date Application Received by Employer (MM/DD/CCYY)		Date Employment Began (MM/DD/CCYY) ★			
Monthly Employee Share \$		Monthly Employer Share \$		Event Date (MM/DD/CCYY) ★		Prospective Date of Coverage (MM/DD/CCYY)			
Payroll Representative Signature					Telephone ()				

ET-2301 (REV 08/2006)

All applicable fields must be completed by the employer





Health Insurance Information Change Form (ET-2329)

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

HEALTH INSURANCE INFORMATION CHANGE

This form is to be completed by a subscriber who is only revising relevant information. Transactions such as changing HMOs or changing from single to family coverage require a new health application (ET-2301) and should not be submitted on this form.

SUBSCRIBER: Complete Sections 1-5. Return form to employer (or ETF if an annuitant).

1. Name _____ Birthdate _____ Social Security Number _____
 Health Insurance Plan _____ Present Coverage: Single Family
 Subscriber # _____ Group # _____

(If retiree or continuant)

I was a dependent or spouse of (name): _____ Social Security Number _____

2. Check the box(es) indicating the type(s) of change(s): Event Date _____
 Name change (list former name) _____
 Address change to: Street: _____
 County _____ City: _____ State: _____ Postal Code: _____
 Home Phone # _____ Daytime Telephone # _____
 Social Security Number _____ for _____
 Selected physician or clinic change to: _____ for _____
 Change in subscriber's physician or clinic county? No Yes, county is _____
 Update other insurance coverage for: _____
 Through State of WI, including University of WI? No Yes Name of Insured _____
 Insurance Company _____ Name of Employer _____
 Group # _____ Subscriber/Policy # _____ Effective Date _____ Medicare? No Yes

3. Complete the following when **adding** a dependent, please list the event date in the grid below (*applicant relationship code on reverse side*):
 Reason: Marriage Student Status Changed Birth Legal Ward* Adoption* Disabled
 *Please attach documentation for additions due to legal ward or adoption status
 Is spouse State of WI employee, including University of WI? Yes No

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Applicant Rel. Code	Selected Physician or Clinic		Event Date
			Mo	Da	Yr				Last Name	First	

Dependents include spouse and children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

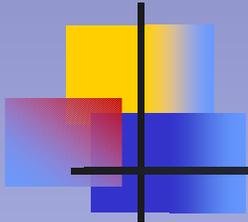
4. Complete the following for **deleting** a dependent. Please list the event date in the grid below:
[Do not use this form to remove last dependent. Please complete new health application (ET-2301) to change to single coverage.]
 Reason: Divorce Age* Dependent Married Student Status Changed Other _____
 *Dependent turned 19 and is not a full-time student; full-time student turned 25; grandchild of a dependent that turned 18.

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Event Date	Dependent's Address (if different than subscriber's)	NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT.
			Mo	Da	Yr					

5. I have read and understand the Terms and Conditions on the reverse side.
 Subscriber Signature _____ Date _____

EMPLOYER COMPLETES AREA BELOW Coding Instructions are in the Employer Health Insurance Manual							
Enrollment Type 65	Employee Type	Coverage Code	Carrier Suffix	Participant County	Physician County	Program Option Code	Surcharge Code
Name of Employer				Employer Number 69-036-	Group Number	Date Received by Employer (MM/DD/CCYY)	
Monthly Employee Share \$	Monthly Employer Share \$	Date Employment Began (MM/DD/CCYY)		Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)	
Payroll Representative Signature						Telephone ()	

ET-2329 (REV 07/2006)



Continuation Conversion Notice (ET-2311)

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

CONTINUATION – CONVERSION NOTICE

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

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

Applicant/Qualified Beneficiary Information:* (To be completed by the Employer)

Employee
 Street and No. _____
 Spouse/Former Spouse Name _____
 City _____ State _____ Zip Code _____
 Dependent Child(ren) Name(s) _____

*Applicant must also complete ET-2301 or ET-2302 if electing to continue or convert coverage, unless applicant is the Employee and will be continuing the coverage in effect.

TO BE COMPLETED BY APPLICANT

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

APPLICANT: Read the instructions on the front before completing this notice. It contains important eligibility and other information concerning your rights and responsibilities. If you wish to continue your coverage, the Department of Employee Trust Funds must receive this notice postmarked within 60 days after your coverage ends or within 60 days of the date shown in Item 8 below, whichever is later.

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

- A I elect to continue coverage under the group health plan for a maximum of 36 months. I understand the health plan will bill me directly for premiums at the above address. OR
- B 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
- C 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
- D (For State participants only) I have 20 years of creditable service, and am terminating state employment. (If electing this option, the Department of Employee Trust Funds must receive this completed notice by the date shown in Item 2. below.)

DIFFERENT COUNTY: I have elected coverage and I live in a county that does not have a primary physician in the current health plan. I have indicated on the application form (ET-2301 or ET-2302) 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 instructions.)

Date (MM/DD/CCYY)	Signature of Applicant	Daytime Telephone ()
-------------------	------------------------	--------------------------

TO BE COMPLETED BY EMPLOYER PRIOR TO GIVING TO THE APPLICANT

EMPLOYER: Federal law requires this notice to be issued to qualified beneficiaries within 14 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.

- Not eligible: (Reason) _____
- Date applicant/qualified beneficiary's coverage ends: _____
- Reason for coverage ending (the qualifying event): (check one)

<input type="checkbox"/> Employment terminated	<input type="checkbox"/> Death
<input type="checkbox"/> Divorce entered	<input type="checkbox"/> Dependent no longer eligible (reason) _____
<input type="checkbox"/> Other _____	
- Date of occurrence in Item 3: _____
- Date employer notified of occurrence in Item 3: _____
- Coverage in effect at time of occurrence in Item 3: Single Family

7.	Name of Health Plan	Monthly Premium Rate: \$		
8.	Completed By	Date Notice Provided (MM/DD/CCYY)	Employer Name	Telephone ()

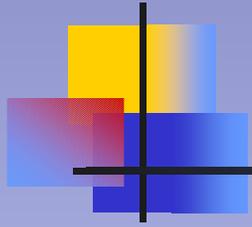
FOR EMPLOYEE TRUST FUNDS USE

New Group Number	Continued Coverage Effective From (MM/DD/CCYY)	Through (MM/DD/CCYY)	By	Date (MM/DD/CCYY)
Telephone:				608-264-7900

ET-2311 (REV 07/2006)

Original – ETF Copy
Pink – Health Plan Copy

Yellow – Acknowledgment Copy
Green – Employer Copy



Transfer Report (ET-1615)

(A fill-in form)

**ON OUR
WEB SITE**

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

GROUP HEALTH INSURANCE TRANSFER REPORT

Wis. Stat. § 40.06

This form is to be completed by the employer when a state employee transfers to another state agency/group or when a local employee leaves active employment and starts employer paid annuitant status. Transactions such as changing HMOs or changing from single to family coverage require a new *Health Insurance Application (ET-2301)* and should not be submitted on this form.

Employee Name (Last, First, Middle Initial)		
Social Security Number	Sex (M/F)	Birthdate (MM/DD/CCYY)
Carrier Name		Carrier Suffix

TRANSFER TO

Employer Name	Employer Number 69-036-	Group Number
Enrollment Type	Employee Type	Coverage Code
Event Date	Coverage Report Month	Coverage Begin Date

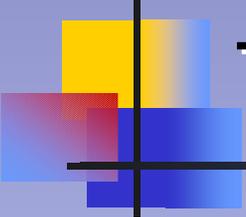
TRANSFER FROM

Employer Name	Employer Number 69-036-	Group Number
	Employee Type	Coverage Code
	Coverage Report Month	Coverage End Date

Payroll Representative Signature	
Date Submitted (MM/DD/CCYY)	Telephone Number

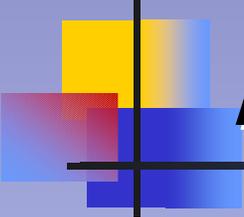
Please make 2 copies of this form.
Send the original to ETF, send one copy to the Carrier, and retain one copy for your records.

ET-1615 (REV 04/2007)

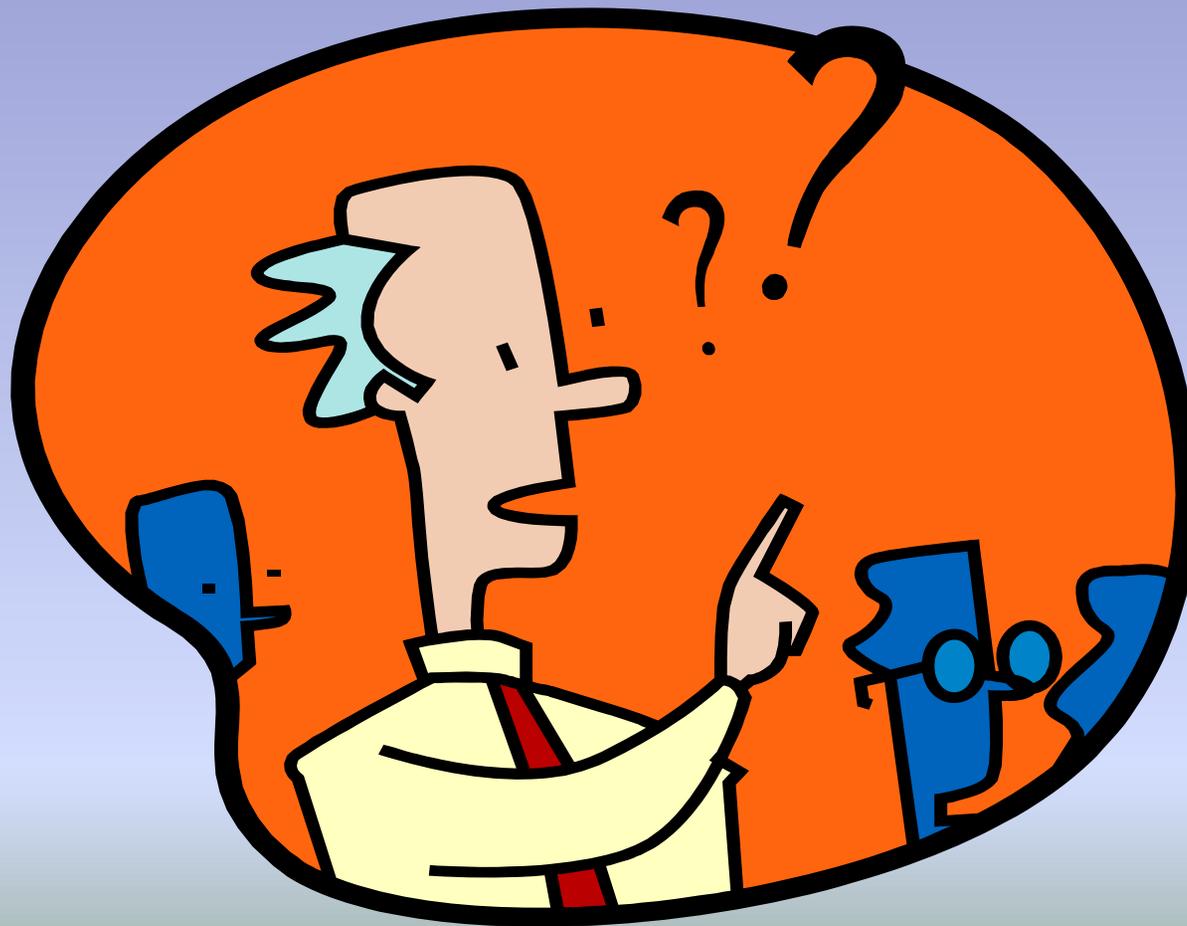


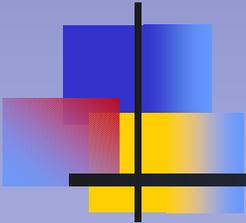
Transfer Report

- Used for changes when retiree transfers from:
 - Active to Employer-Paid Annuitant or Regular Retirees
 - Employer-Paid Annuitant to Regular Retiree
- Complete no more than two months in advance of change
- For Regular Retirees, complete only the “From” portion and
 - Immediately mail or fax to ETF (608) 261-8177
- For Employer-Paid Annuitants, complete both the “To” and “From” portions and
 - Immediately mail or fax to **both** ETF and carrier



Any Questions???????

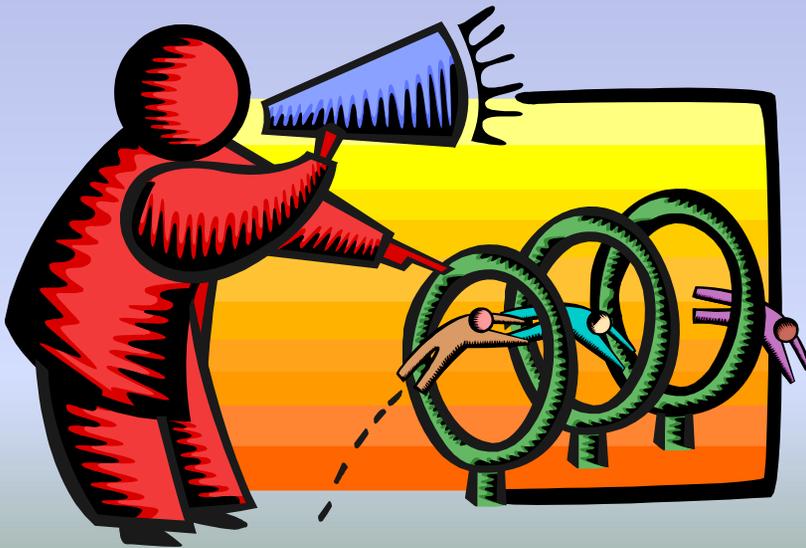


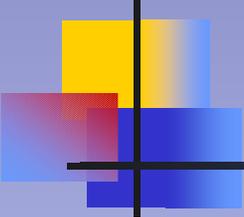


Monthly Reporting

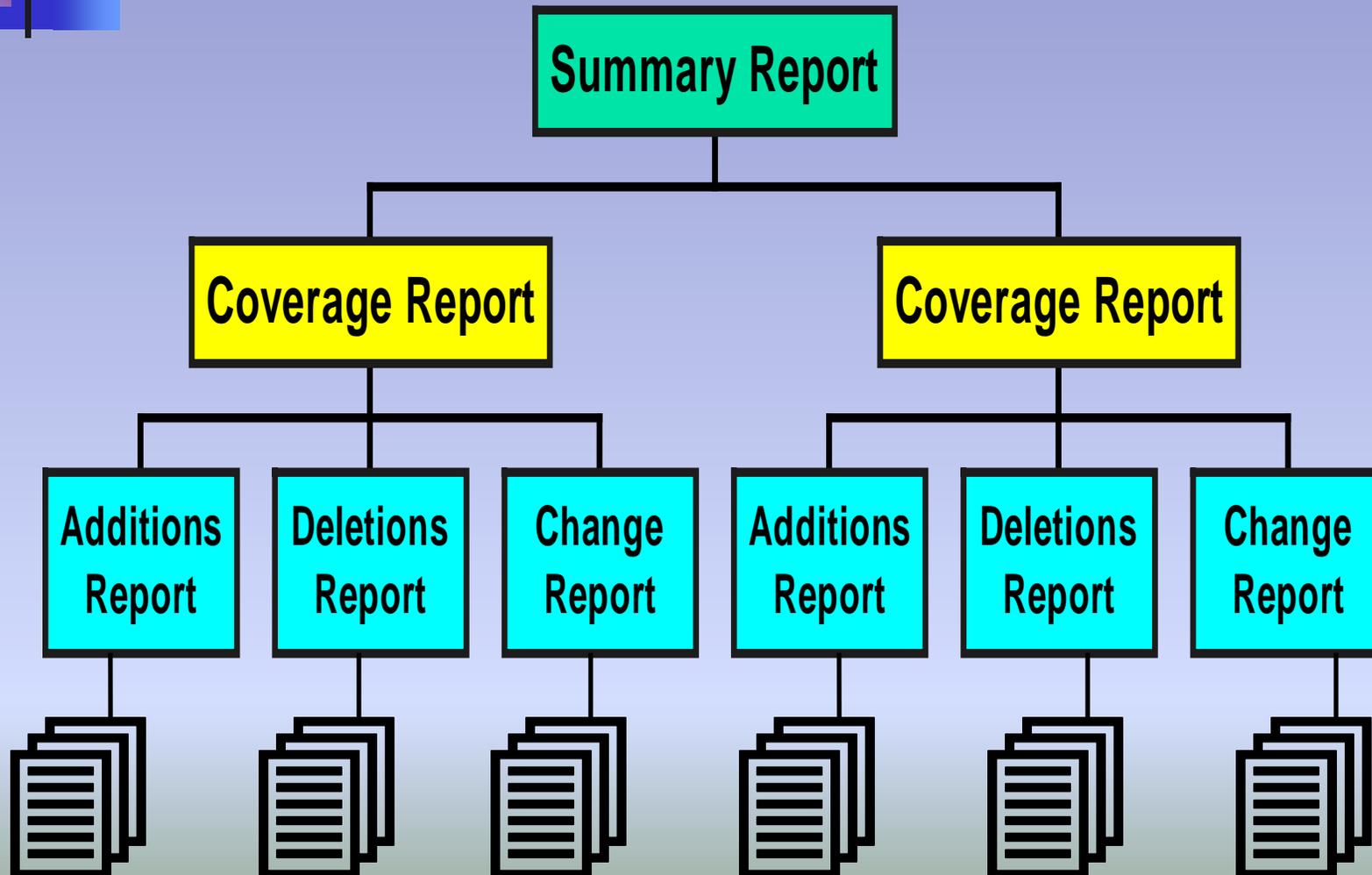
"Success seems to be largely a matter of hanging on after others have let go."

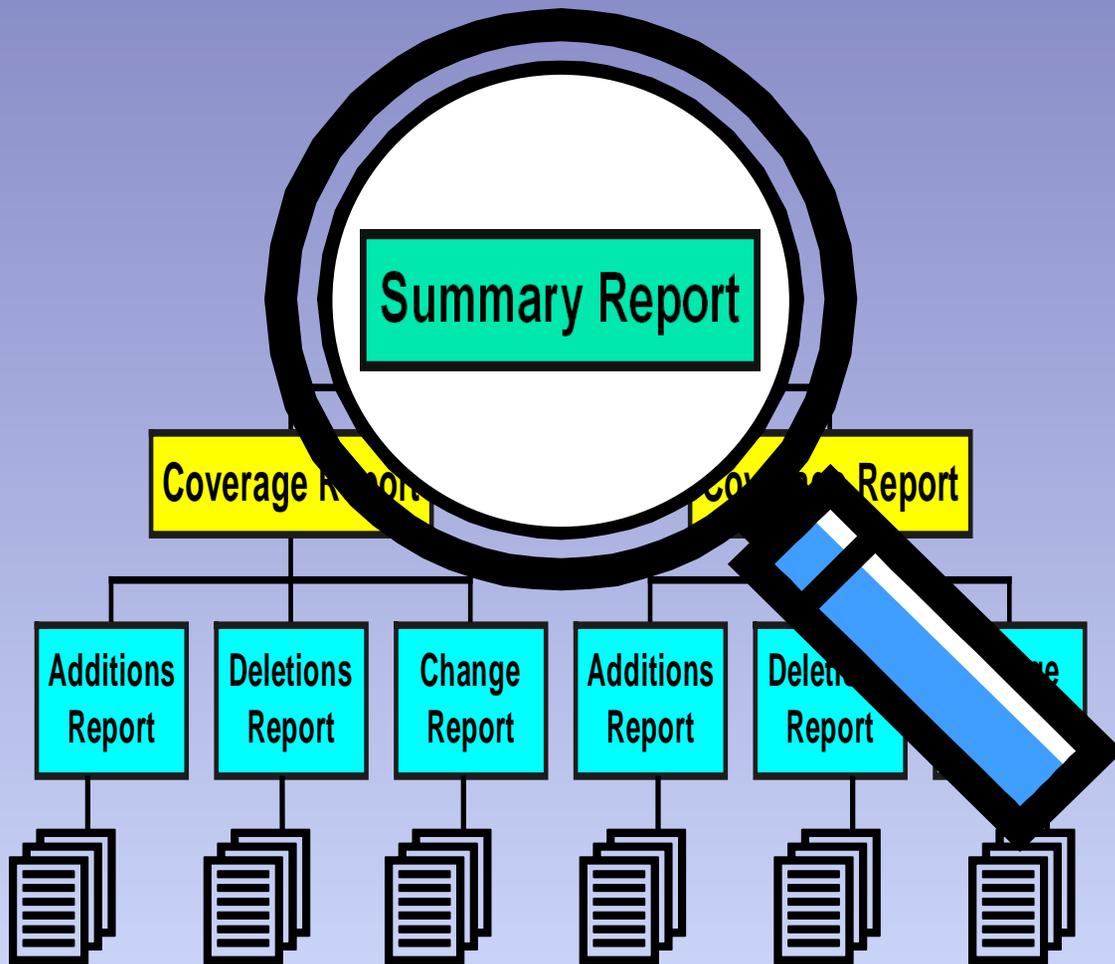
~ William Feather



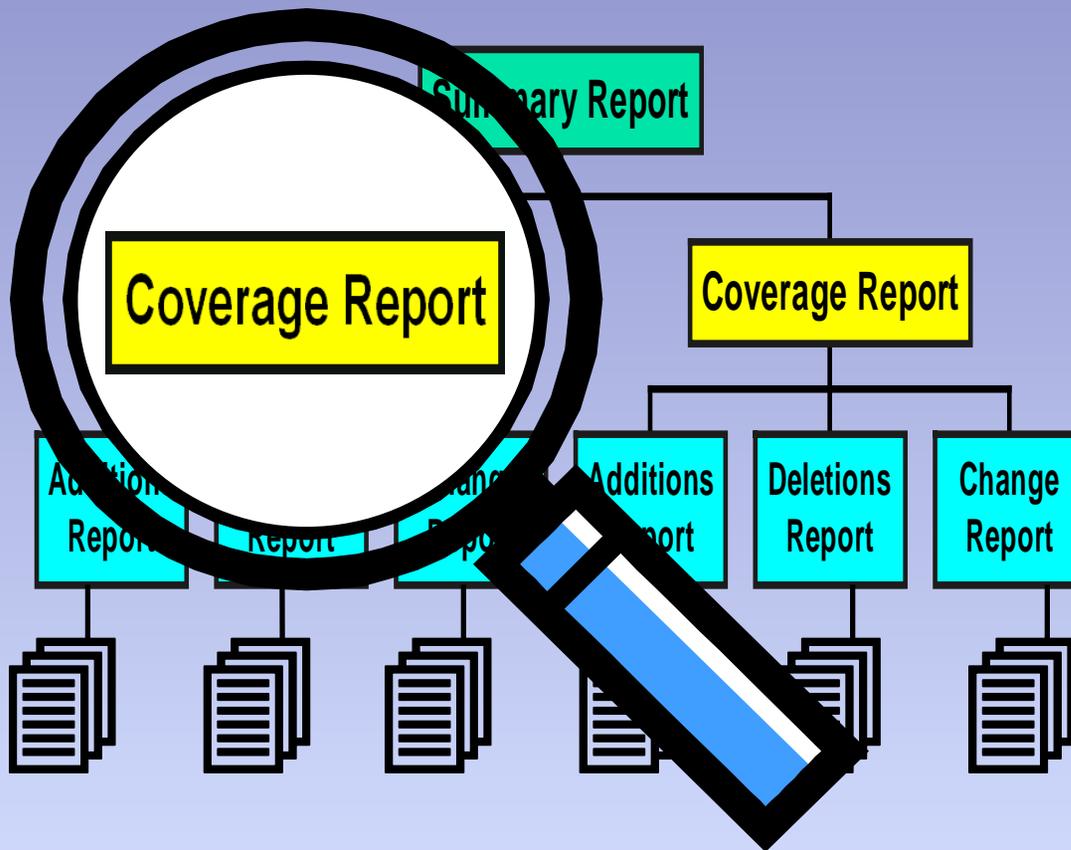


Overview of Monthly Reports

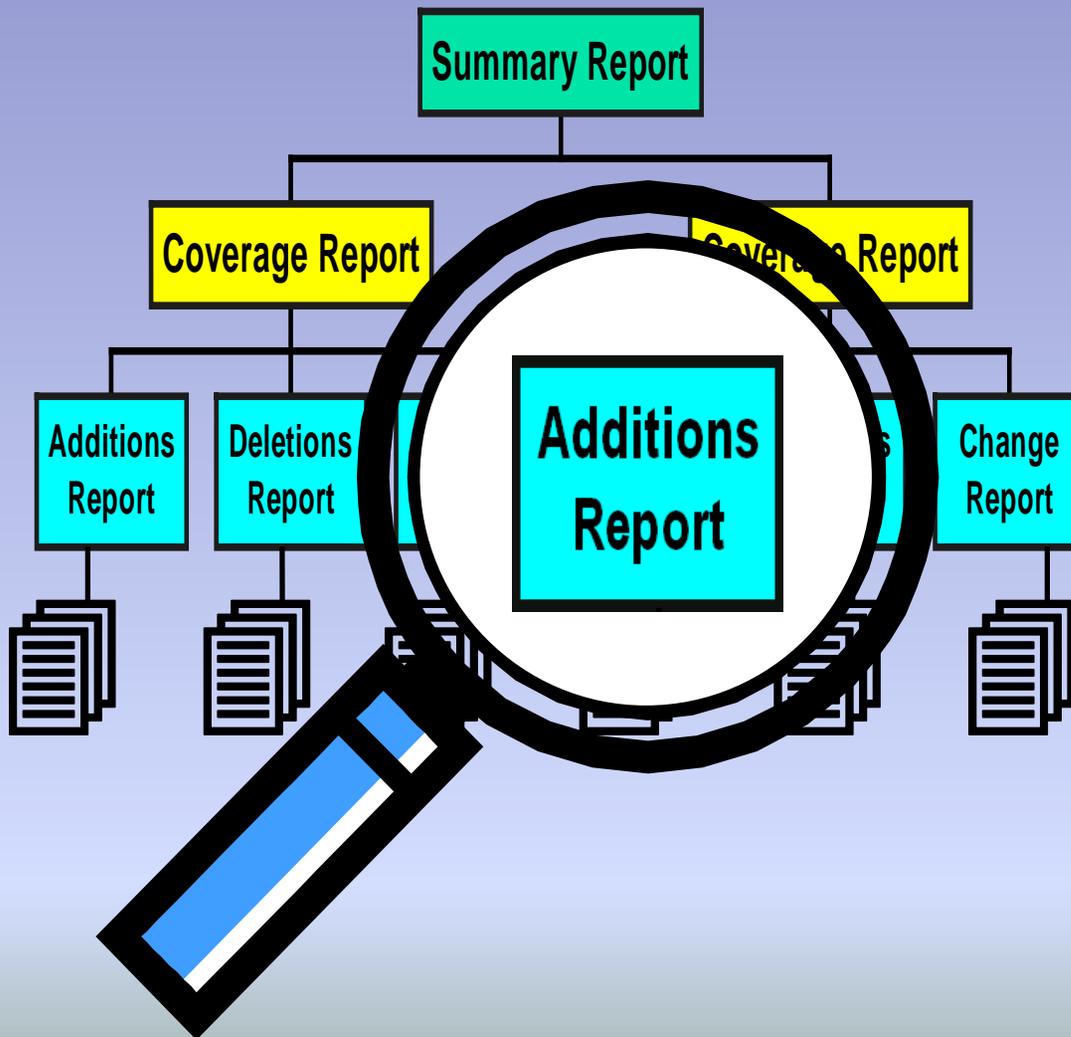




- Summarizes all health plans for the month



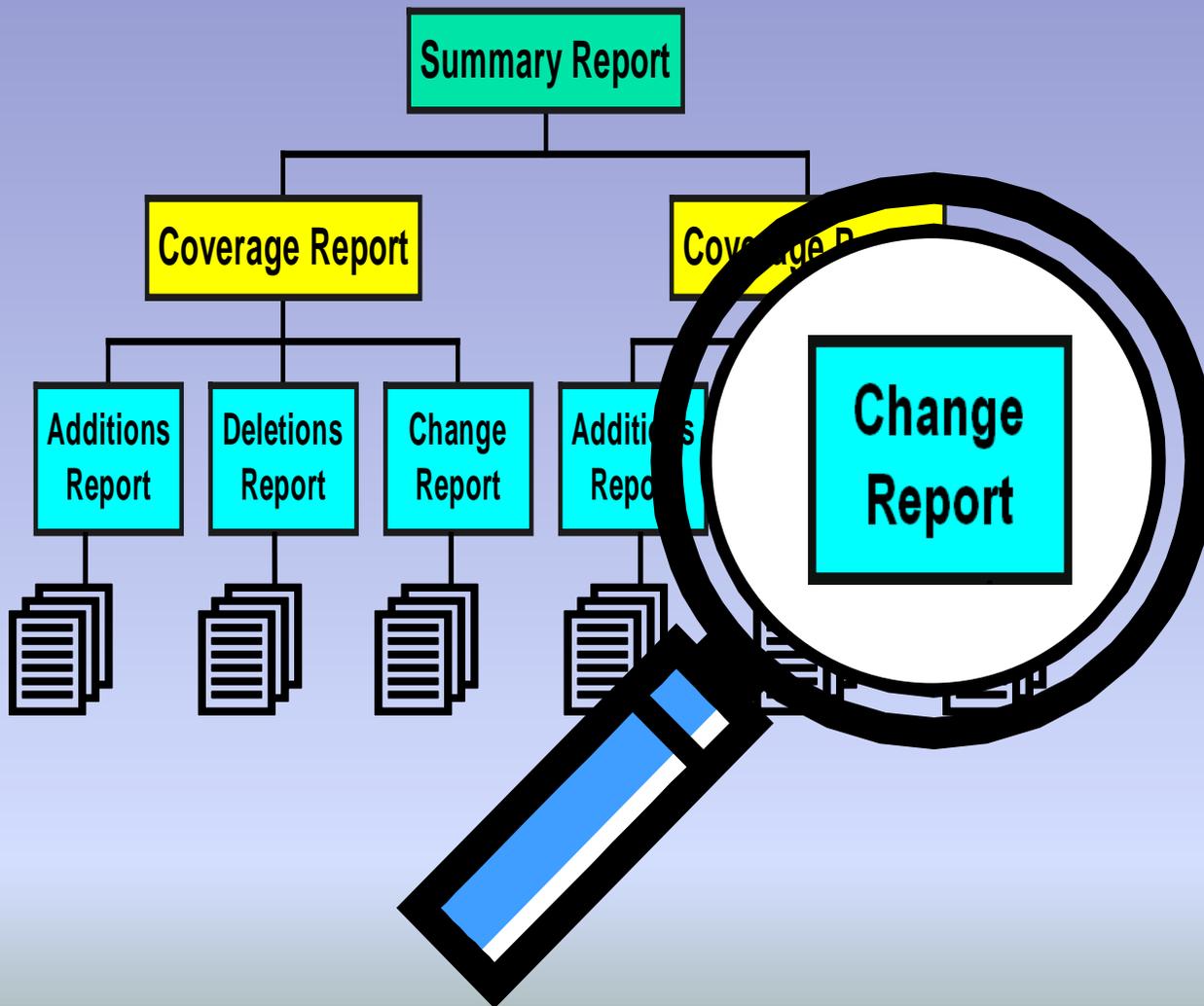
- Summarizes contracts for each carrier
- Fill out a Coverage Report for each carrier
- One for Dean, Standard Plan, GHC, etc.



- Lists contracts added to this particular carrier for the month
- Attach Health Insurance Application (ET-2301)



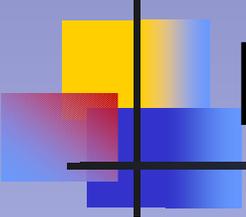
- Lists contracts deleted from this particular carrier for the month
- Attach Health Insurance Application (ET-2301) only when canceling coverage



- Lists coverage changes within this particular carrier

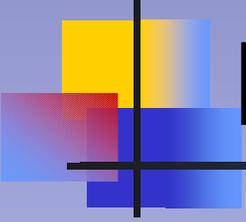
family to single
or
single to family

- Attach Health Insurance Application (ET-2301)



Monthly Reports

- For active employees and Employer-Paid Annuitants, the reports used are:
 - *Monthly Additions Report* (ET-2610) - reports new contracts
 - *Monthly Deletions Report* (ET-2612) - reports terminating contracts
 - *Monthly Changes Report* (ET-2614) - reports coverage changes
 - *Monthly Coverage Report* (form number varies) - summarizes additions, deletions and changes for each health plan
 - *Health Insurance Summary* (form number varies) - summarizes all plans from the coverage reports



Monthly Additions Report

- Lists each employee with a new contract
- The enrollment type/code provides the reason the contract is being added (*Health Insurance Manual* - Chapter 11, Section 1104)
- Coverage Report Copy of each *Health Insurance Application* (ET-2301) must be attached to the report

Each health plan must have a separate report

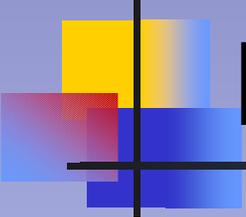
Monthly Additions Report ET-2610

Department of Employee Trust Funds
801 W. Badger Road
P.O. Box 7931
Madison, Wisconsin 53707-7931

GROUP HEALTH INSURANCE MONTHLY ADDITIONS REPORT Wis. Stat. § 40.06

Employer Name		Employer Number	Group #	Carrier Suffix	Deduction Month	Coverage Month				
Town of ABC		69-036- 1234-000	71234	.15		05/07				
Enrollment TypeCode	Employee TypeCode	EMPLOYEE		Date of Hire or Re-hire	If changing carrier, provide previous carrier suffix	Effective Date	Contract Type		PREMIUM ADJUSTMENT PREVIOUS MONTH(S) (List individual months)	
		Name Last, First, Middle I.	Social Security No.				Single	Family	Month	Amount
02	06	Smith, Amanda	123-45-6789	1/5/2007		2/1/2007	01		02/07	\$ 418.60
									03/07	\$ 418.60
									04/07	\$ 418.60
66	06	Rodriguez, Maria (Correction to the 4/07 Monthly Report)	891-23-4567	3/1/2007		3/1/2007			03/07	\$ 1042.80
41	06	Rodgers, Andrea	789-12-3456	3/21/1977	.40	5/1/2007		02		
31	06	Johnson, Kelly	678-91-2345	12/1/2005	.A5	5/1/2007		02		
05	06	Swanson, Katie	567-89-1234	8/31/2004		5/1/2007	01			
03	06	Hansen, Kim	456-78-9123	5/17/2005		5/1/2007	01			
TOTAL ADDITION IN CONTRACTS							3	2		\$ 2,298.60

Add totals to Coverage Report



Monthly Deletions Report

- Lists each employee whose contract is ending
- The enrollment type/code provides the reason the contracts ending
- For cancellation of coverage, Coverage Report Copy of each application (ET-2301) must be attached
- Deletion chart indicates effective dates and required forms with adjustments/refunds/comments

Each health plan must have a separate report

Monthly Deletions Report ET-2612

Department of Employee Trust Funds
801 W. Badger Road
P.O. Box 7931
Madison, Wisconsin 53707-7931

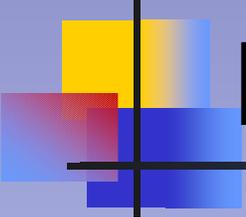
GROUP HEALTH INSURANCE MONTHLY DELETIONS REPORT

Wis. Stats. § 40.06, 40.51 (7)

Enrollment Indicator
4

Employer Name **Town of ABC** Employer Number **69-036-1234-000** Group # **71234** Carrier Suffix **.15** Deduction Month Coverage Month **05/07**

Enrollment Type Code	Employee Type Code	EMPLOYEE		Birthdate	If changing carrier, provide new carrier suffix	Event Date	Effective Date	Contract Type		PREMIUM ADJUSTMENT PREVIOUS MONTH(S) (List individual months)		
		Name (Last, First, Middle I.)	Social Security No.					Single	Family	Month(s)	Amount	
10	06	Browne, Jackson	123-45-6789	12/23/50		2/23/07	3/1/07		02	03/07	(1042.80)	
										04/07	(1042.80)	
41	06	Hughes, Sally	912-34-5678	1/3/68	.47	3/23/07	4/1/07	01		04/07	(418.60)	
Add totals to Coverage Report												
TOTAL DECREASE IN CONTRACTS										(Post to Line 3 of the Monthly Coverage Report)		
										1	1	(2504.20)



Monthly Change Report

- Used for coverage changes (single to family - family to single) within a plan
- The enrollment type/code provides the reason for the change
- Coverage Report Copy of each application (ET-2301) must be attached to the report
- Coverage change chart indicates effective dates and adjustments/refunds/comments

Each health plan must have a separate report

Monthly Changes Report ET-2614

Department of Employee Trust Funds
801 W. Badger Road
P.O. Box 7931
Madison, Wisconsin 53707-7931

GROUP HEALTH INSURANCE MONTHLY CHANGES REPORT

Wis. Stat. § 40.06

Employer Name Town of ABC	Employer Number 69-036-1234-000	Group # 71234	Carrier Suffix .15	Deduction Month	Coverage Month 05/07
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Enrollment Type	Employee Type	Name Last, First, Middle I.	Social Security No.	Effective Date of Change	TYPE OF CONTRACT												PREMIUM ADJUSTMENT PREVIOUS MONTH(S) (List individual months)	
					FROM				TO									
					Regular Plan		Medicare Supplement		Regular Plan		Medicare Supplemental		Month	Amount				
43	06	Knot, Tyler	234-56-7890	4/16/07	01						02							
44	06	Taylor, Sarah	345-67-8901	3/1/07		02					01				03/07	(624.20)		
															04/07	(624.20)		
43	06	Miller, George	456-78-9012	4/10/07	01						02				04/07	624.20		
TOTAL CHANGE						02	01				01	02					(624.20)	

Credit is difference between family & single premiums

Amount owed is difference between single & family premiums

Add totals to Coverage Report

(LINE 5 - DECREASE) (LINE 4 - INCREASE)

ET-1630

Monthly Coverage Report

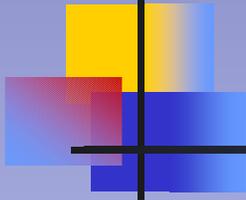
Next Month's "Contracts in Effect"

Totals Transferred To Summary

Employee Trust Funds Group Health Insurance		Employer No. (EIN) 69-036- 1234-000	Deduction Month 05/07	Coverage Month 05/07	Suffix .15
WPE TRADITIONAL HMO/CLASSIC STANDARD PLAN PGM OPT P02 & SRCHG S01 2007 MONTHLY COVERAGE REPORT		Employer Name Town of ABC		Group No. 71234	
		Single Contracts		Family Contracts	
1. Contracts in Effect Last Month:		12		14	
2. Additions Report: (+)		3		2	
3. Deletions Report: (-)		(1)		(1)	
4. Changes Report: "To" (+)		1		2	
5. Changes Report "From": (-)		(2)		(1)	
6. Contracts in Effect This Month:		13		16	
7. Plan	Suffix				
Standard - Dane	.A1	928.20		2317.50	
Standard - Milwaukee	.A2	1083.30		2705.20	
Standard - Waukesha	.A3	1001.70		2501.20	
Standard - Balance of State	.A4	1001.70		2501.20	
State Maintenance Plan (SMP)	.A5	666.10		1661.90	
CompcareBlue Southeast	.11	648.00		1616.30	
CompcareBlue Northwest	.13	602.70		1729.00	
Dean Health Plan	.15	418.60		1042.80	
Humana - Eastern	.21	650.70		1645.50	
Humana - Western	.22	697.20		1739.30	
GHC - Eau Claire	.30	614.30		1532.00	
GHC - South Central	.35	416.40		1037.30	
Gundersen Lutheran	.37	627.90		1566.00	
Unity - Community	.40	405.80		1010.80	
WPS Prevea/Arise Health Plan	.47	518.50		1292.50	
Health Tradition	.55	567.80		1415.80	
Medical Associates HMO	.63	445.60		1110.30	
MercyCare Health Plan	.64	368.50		917.50	
Network Health Plan	.70	455.70		1135.50	
Security Health Plan	.71	682.00		1701.30	
Physicians Plus - Meriter & UW	.74	386.20		961.80	
WPS Patient Choice Plan 1	.81	614.10		1531.50	
WPS Patient Choice Plan 2	.82	669.10		1669.00	
UnitedHealthcare - Southeast	.83	555.70		1385.50	
Unity - UW Health	.92	408.70		1018.00	
UnitedHealthcare - Northeast	.94	488.00		1216.30	
8. Subtotals (No. of Contracts x Premiums)	8a	\$ 5,441.80	8b	\$ 16,684.80	
A. Employee Share =	\$ 10,648.40	**	(Line 8a + Line 8b)	9. Subtotal	\$ 22,126.60
B. Employer Share =	\$ 10,648.40	**	10. Adjustments	\$ (829.80)	\$ 2,298.60
C. Total* (Lines A + B) =	\$ 21,296.80	**	(Line 9 + Line 10)	11. Grand Total*	\$ 21,296.80
* NOTE: Figure entered on line C must equal figure entered on line 11. ** NOTE: Figure entered must correspond to this plan's entry on the summary.					
Date (MM/DD/YYYY)	Prepared By	Telephone			
ET-1630 (REV 11/2006)					
Check the type of employer contribution: <input type="checkbox"/> Tiering <input checked="" type="checkbox"/> 105%					

\$ 2,298.60
(\$ 2,504.20)
(\$ 624.20)

ET-1631



Monthly Summary Report

**Due by 20th
of each month**

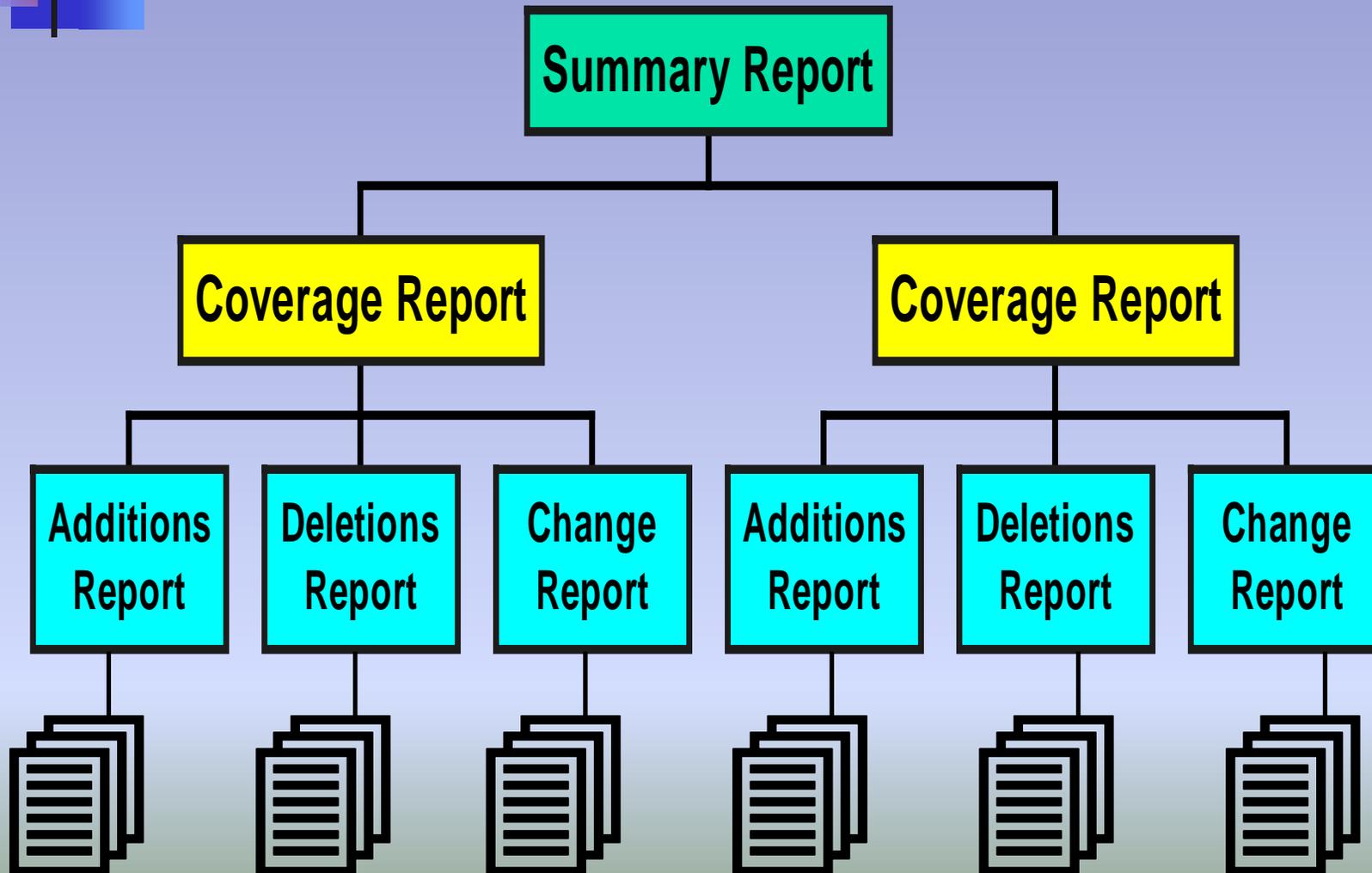
Department of Employee Trust Funds
801 W. Badger Road, Madison, WI 53702-0011

**WPE TRADITIONAL HMO/CLASSIC STANDARD PLAN
PGM OPT 02 & SRCHG S01
HEALTH INSURANCE SUMMARY – 2007**

EMPLOYER NAME		EMPLOYER NO. (EIN)	COVERAGE MONTH	
Town of ABC		69-036- 1234-000	05/07	
PLAN	SUFFIX NO.	EMPLOYEE SHARE	EMPLOYER SHARE	TOTAL
CompcareBlue Southeast	.11	\$ 25,498.50	\$ 25,498.50	\$ 50,997.00
CompcareBlue Northwest	.13			
Dean Health Plan	.15	\$ 10,648.40	\$ 10,648.40	\$ 21,296.80
CompcareBlue – Aurora/Family	.16			
Humana – Eastern	.21			
Humana – Western	.22			
GHC - Eau Claire	.30	\$ 23,021.06	\$ 23,021.06	\$ 46,042.12
GHC - South Central	.35			
Gundersen Lutheran	.37			
Unity-Community	.40			
WPS Prevea/Arise Health Plan	.47			
Health Tradition	.55			
Medical Associates HMO	.63	\$ 19,321.84	\$ 19,321.84	\$ 38,643.68
MercyCare Health Plan	.64			
Network Health Plan	.70			
Security Health Plan	.71			
Physicians Plus – Meriter & UW	.74			
WPS Patient Choice Plan 1	.81			
WPS Patient Choice Plan 2	.82			
UnitedHealthcare – Southeast	.83			
Unity - UW Health	.92			
UnitedHealthcare – Northeast	.94			
SUBTOTAL ALT. HEALTH		\$ 78,489.80	\$ 78,489.80	\$ 156,979.60
Standard – Dane	.A1	\$ 30,321.84	\$ 30,321.84	\$ 60,643.68
Standard – Milwaukee	.A2			
Standard – Waukesha	.A3			
Standard – Balance of State	.A4			
State Maintenance Plan (SMP)	.A5			
SUBTOTAL STD. HEALTH		\$ 30,321.84	\$ 30,321.84	\$ 60,643.68
Over/Under Payment (only if requested by ETF)				\$ 1,000.00
GRAND TOTALS		\$ 109,854.44	\$ 109,854.44	\$ 218,623.28

Date (MM/DD/YYYY)	Prepared By	Telephone
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Overview of Monthly Reports

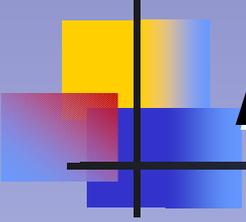


Monthly Billing Information

- Premium payments are due by the 20th of each month preceding the coverage month
- Checks should be payable to “Employee Trust Funds”
- Interest will be charged for late received payments

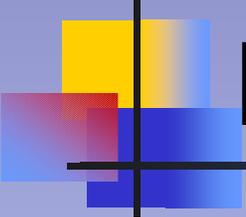


DEPT OF EMPLOYEE TRUST FUNDS
P O BOX 78761
MILWAUKEE WI 53278-0761



Any Questions???????





Problems With Benefits

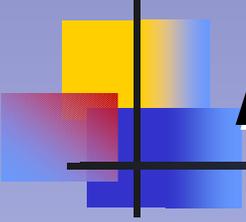
- For denials of health insurance or pharmacy benefit claims or referrals, employees should contact:
 - Health Insurance: the health plan's customer service area
 - Each plan has a grievance resolution process in place
 - After exhausting all levels of appeal with the plan, employees can submit an *Insurance Complaint* form (ET-2405) to the ETF Quality Assurance Services Bureau (QASB) for administrative review
 - Pharmacy Benefits: Navitus Health Solutions' customer service area (for active employees or annuitants not yet on Medicare Part D)
 - Has a grievance process in place for denied benefits
 - After exhausting all levels of appeal with Navitus, employees can submit an *Insurance Complaint form* (ET-2405) to the QASB for administrative review

ET-2405
is on our
web site

Questions

- Contact Employer Communication Center, toll free (888) 681-3952 or locally (608) 264-7900 for questions on:
 - Eligibility for coverage
 - Enrolling employees
 - Monthly billing and reporting
- Contact the plan or Navitus directly for questions on:
 - Benefits
 - Exclusions
 - Limitations
 - Participating providers





Agenda - Part 1 and 2



- Part 1:

- Enrollments
- Due Dates & Effective Dates



- Part 2:

- Loss of Coverage
- Continuation/Conversion Rights
- Employees Retiring



Thank you for watching!

