



STATE OF WISCONSIN

## Department of Employee Trust Funds

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Secretary

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DATE: December 1, 2000

TO: All Participating Health Plans

FROM: Phyllis Fuller, Policy Analyst  
Division of Insurance Services  
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SUBJECT: Annual Student/Dependent Status Letter

cc: State and Local Health Employers

### Annual Student/Dependent Status Letter

Enclosed is the 2001 Full-time Student/Dependent status letter. These letters should not be sent before December 15, 2000 and no later than January 15, 2001. Plans will be permitted to terminate dependents for whom no reply is received by February 16, 2001. We encourage plans to send a follow-up letter to members who have not responded within two weeks of receiving the questionnaire. The termination date for former dependents is the last date of eligibility. In most cases this is December 31, 2000. **If evidence of continued eligibility is later provided, coverage must be reinstated back to the date of termination.**

Changes to the subscriber letter and questionnaire are shown with redlining. Please send this document as a two sided form.

In order to address situations where the subscriber has selected another plan for the 2001 Dual-Choice Enrollment period, you should also use the advance carrier copy of Dual-Choice applications to send this questionnaire to new subscribers who will be effective with your plan on January 1, 2001. While this may result in some duplication, we believe it is the best way to ensure that each plan gets the necessary information for its current and newly acquired members.

As was the case last year, your plan should reproduce this letter on its letterhead. You may use your own header and include or request necessary information regarding the subscriber's name and identification number, group number, the dependent's name and identification number and date of birth. A larger font size may be used. The letter must be sent with a pre-addressed return envelope or as a self-mailer. The envelope is not required to be prepaid, but that may increase the response rate.

If, after reviewing the completed student status letter, the plan determines that the subscriber no longer has a covered dependent, the subscriber's coverage should automatically be changed from family to single. Please forward changes of this type to James Krawczyk at the address above and to the appropriate employer. This notification should include the following: the subscriber's and the dependent's names, the subscriber's and the dependent's Social Security numbers, the effective date of the dependent's termination of coverage, and the employer's identification number, and group number. This listing should be sorted by group number at a page break.

If the plan has additional questions regarding a particular dependent's eligibility, the plan may request verification, such as proof of enrollment as a full-time student or review of disability status by a consulting physician or mental health provider.

If disability status is claimed, the contract requires that the dependent be considered to have a long standing disability or be disabled for an indefinite duration. Generally, long standing and indefinite duration means that the disability is expected to continue for at least a year or until the next student/dependent questionnaire period, whichever occurs later.

**COB:** Questions regarding coordination of benefits are not included on the questionnaire. However, plans may request information regarding other insurance, on separate paper, along with the mailing of this questionnaire. As many employers have plan changes on January 1, this may be a good time for plans to collect COB information from all subscribers.

A copy of the most recent Employer Contacts for insurance programs management is enclosed.

***Reminder:***

Previously, plans were required to send the COBRA notice to Dual-Choice enrollees and to new plan subscribers throughout the year. The COBRA notice is now included in the *It's Your Choice* book (2001). Plans are no longer required to send the notice.

Enclosures



## Immediate Attention Required!

To the best of your knowledge, please answer the following for coverage year 2001. If there is any change in your dependent's eligibility after this questionnaire is completed, notify your payroll/personnel office as soon as the change occurs.

1. Is the dependent child your natural, step or adopted child, or a child who became the subscriber's permanent legal ward prior to age 19? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Is the child dependent upon you or the other parent for at least 50% of his or her support and does he or she meet the support tests as a dependent for income tax purposes (whether or not the child is actually claimed)? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Is the dependent child unmarried? Yes \_\_\_\_\_ No \_\_\_\_\_  
If married, provide date of marriage: \_\_\_\_\_  
(Note: Coverage ends on the last day of the month in which the marriage occurs.)
4. In 2001, will the dependent child be enrolled in, and attending as a full-time student, an institution that provides a schedule of classes and whose principal activity is the procurement of an education?  
Yes \_\_\_\_\_ No \_\_\_\_\_

**If yes\*:** Name of school: \_\_\_\_\_  
Anticipated graduation date: \_\_\_\_\_

**If no:** Date full-time attendance ceased: \_\_\_\_\_

\*If your response to question 4 is yes but the dependent does not return to school as a full-time student during the spring semester of 2001, you must notify your payroll representative immediately. Failure to do so may result in unpaid claims as this individual may no longer be considered an eligible dependent on your health insurance contract.

5. Is the dependent child incapable of self-support due to a mental or physical disability which is expected to be of long-continued or indefinite duration (generally one year or more)?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate the diagnosis and provide the name and telephone number of the attending physician who can be contacted to verify the disability: \_\_\_\_\_  
\_\_\_\_\_

Your child will continue to be covered as your dependent if the answers to questions 1, 2 and 3 above are yes and the child is either a full-time student(4) or is disabled and incapable of self support(5).

If you have any questions regarding this form, please call our \_\_\_\_\_ department at \_\_\_\_\_.

To the best of my knowledge all statements and answers above are complete and true. All information is furnished under penalty of Wis. Stats. § 943.395. I understand that fraud or material misrepresentation of the child's eligibility for coverage will result in termination retroactive to the date eligibility was lost and I or my dependent will be responsible for the cost of service provided during the period when coverage was erroneously in effect.

Date (MM/DD/CCYY)

Signature of Subscriber