COBRA Continuation-Conversion Notice: How to Apply

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

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 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.

How to Elect Continuation (COBRA) Coverage

1. If applying for COBRA, check box A (COBRA election) on the attached Continuation-Conversion Notice form; 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. If you do not fall in either A or B, please review the explanation of who is eligible for Conversion under C below in "General Information."
4. Please read the information about Other Coverage and Medicare under D below in "General Information."
5. 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 employee's former employer or go online to 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.
6. 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 your premium on a monthly basis, in which case your health plan will bill you directly.
7. **Canceling COBRA Coverage** — After applying for COBRA if you wish to cancel coverage, you must submit your request to ETF in writing. Coverage ends at the end of the month following receipt of your written request to ETF unless you are canceling due to enrolling in other coverage.

   If, when you apply for coverage, you know you will want to cancel coverage after 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.

This notice does not fully describe continuation coverage or other rights under this plan. More information is available online at etf.wi.gov/health-benefits/state-and-federal-notifications and in ETF's Frequently Asked Questions on COBRA/Continuation of Health Coverage If you have questions concerning the information in this notice, your rights to coverage, or to obtain a copy of the health benefits guides, contact the employer entered on Item 8 of the notice or ETF at 1-877-533-5020.

Enclosed:

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 or dependent child;
- 36 months after employee's divorce for the spouse or dependent child;
- 36 months after employee's death for the spouse or dependent child;
- 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 the following into account: First, other coverage alternatives may be available to you through the Health Insurance Marketplace where you may be eligible for a tax credit that lowers monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments). You have 60 days from the time you lose your employment-based coverage to enroll in the Marketplace. Through the Marketplace you may also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You also have the right to enroll in the Marketplace if you have a qualifying event, a special enrollment period or your COBRA has been exhausted. For more information about options available through a Health Insurance Marketplace, visit healthcare.gov.

Second, you should take into account that you have special enrollment rights under federal law. 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 open enrollment period. Continue to reference your 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 our 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. COBRA coverage ends for a QB (including Subscriber) when they become entitled to Medicare benefits. If the QB is part of a family contract, the non-Medicare members may remain on the COBRA policy until the original expiration date of that contract. If you elect continuation coverage, an extension of the maximum period may be available if a QB is determined by the Social Security Administration to be disabled, or a second qualifying event occurs in the first 18 months.

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 C, 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. Coverage will **not** be the same policy as provided through ETF.

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. 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 by 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 and your COBRA coverage will end under this program.

Continuation-Conversion Notice

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

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

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

Subscriber or Qualified Beneficiary Information Required; must be completed by the employer			
	ETF ID or last four digits of SSN	**Name** (First, Middle, Last)	**Birth date** (MM/DD/YYYY)
☐ Employee			
☐ Spouse			
☐ Child			
Mailing Address (Street, City, State, ZIP code)			

Employer: Complete before giving this form to the qualified beneficiaries

Employer: State 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 mo. Max continuation coverage)
   - ☐ Termination due to layoff or leave of absence end (36 mo. max. continuation coverage)
   - ☐ Death (36 mos. max. continuation coverage)
   - ☐ Divorce (36 mos. max. continuation coverage)
   - ☐ Dependent no longer eligible (36 mos. max. continuation coverage)
   - ☐ Other (e.g. SSA disability) _____
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/YYYY):	Employer name/number (7-digit)	Group number:	Telephone number, including area code

Qualified beneficiary must complete next page.

Qualified Beneficiary: Complete this section

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

Read the How to Elect COBRA/Continuation and General Information before completing this notice. They contain 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 ETF. Coverage ends at the end of the month following receipt of your written request by ETF, unless you have enrolled in other group coverage.

Check Only One - Box A, B, or C. See the general information for explanations of 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 above on page 3. I understand the health plan will bill me directly for premiums at the above address; or

B ☐ COBRA election while my WRS 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 above on page 3. 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.

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 health 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 4 under " How to Elect Continuation (COBRA) Coverage" and also Section D, "Other Coverage/Medicare," under the general information on Page 2.)

Signature	Date (MM/DD/YYYY)	Telephone, including area code

ETF Use Only				
New group number	Continued coverage from (MM/DD/YYYY)	Through	Telephone number 1-877-533-5020	
			By	Date:

Employer Instructions: Please complete the employer section of this form as follows:

Please complete the Subscriber ETF ID and Subscriber SSN at the top left of page 3, the application.

It is the employer's responsibility to check a box for those relationships (employee, spouse, child, etc.) being offered continuation coverage and to provide ***all*** requested information, including a mailing address. If more lines are needed, please add an additional copy of the application and mark as "Page 2."

Line 1: If the qualified beneficiary is not eligible to continue coverage, provide the reason here (ex: termed for cause).

Line 2: List the actual date the coverage will end for the qualified beneficiary(ies).

Line 3: Check the box by the applicable reason coverage has ended for the qualified beneficiary(ies).

Line 4: Provide the date the event in line 3 occurred.

Line 5: Provide the date you were notified of the event in line 3.

Line 6: Indicate what health insurance coverage was in effect when the event happened.

Line 7: Provide the name of the health plan the qualified beneficiary(ies) had at the time of the event in line 3 and indicate the premium rate for both single and family coverage.

Line 8: Sign and date the form, provide your ETF employer number, and your phone number.

If you must reissue this form due to an error, use the same dates as originally entered on **all** lines. To do otherwise could affect eligibility for the qualified beneficiary(ies).

Nondiscrimination and Language Access

42 U.S. Code § 18116

ETF complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and others). ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact ETF at 1-877-533-5020; TTY: 711.If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

ETF Office of Policy, Privacy & Compliance
P.O. Box 7931
Madison, WI 53707-7931

1-877-533-5020; TTY: 711
Fax: 608-267-4549
Email: ETFSMBPrivacyOfficer@etf.wi.gov

If you need help filing a grievance, ETF's Office of Policy, Privacy & Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019; 1-800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/complaints/index.html.

The Wisconsin Department of Employee Trust Funds is a state agency that administers the Wisconsin Retirement System pension, health insurance and other benefits offered to eligible government employees, former employees and retirees.

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj xav tau kev pab txhais lus. Peb pab koj tau, peb pab koj dawb xwb, thov hu rau 1-877-533-5020 (TTY: 711)

Chinese– 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：711）

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).

Arabic – ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 711)

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)번으로 전화해 주십시오.

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 711).

Pennsylvania Dutch – Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 711).

Laotian/Lao – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 711).

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 711).

Hindi – ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 711) पर कॉल करें।

Albanian – KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 711).