State of Wisconsin
ELECTION OF CONTINUED VISION COVERAGE

DESCRIPTION OF QUALIFYING EVENT:

- ❑ Disabled on the date of qualifying event
- ❑ Termination of Marriage
- ❑ Leave of absence - Dates from _____ to _____
- ❑ Loss of child's dependent status
- ❑ Reduction of hours
- ❑ Retiree
- ❑ Surviving Dependent
- ❑ Termination of Employment
  - ❑ Voluntary Termination
  - ❑ Involuntary Termination

COBRA APPLICANT INFORMATION:

Name of COBRA Applicant (Last, First, Middle Initial)	Daytime Telephone Number ( )	Sex ❑ Male ❑ Female
Mailing Address (Number, Street, City, State, ZIP)		
Social Security Number	Birth Date (Month/Day/Year)	Marital Status ❑ Married ❑ Single

CURRENT/FORMER EMPLOYEE INFORMATION:

Name of Employee	Social Security Number of Employee	Relationship to Applicant

ELIGIBLE FAMILY MEMBERS (List dependents to be enrolled. Attach separate listing if more dependents exist.):

Name (Last, First, Middle Initial):	Social Security Number:	Birth Date (Month/Day/Year)	Sex	Relationship to Employee
			❑ Male ❑ Female	
			❑ Male ❑ Female	
			❑ Male ❑ Female	
			❑ Male ❑ Female	

ELIGIBILITY PERIODS:

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows an employee whose group insurance terminates due to reduction of work hours or termination of employment - for reasons other than gross misconduct - to continue their insurance coverage for themselves for up to 18 months. Surviving dependents, divorced or legally separated spouses and dependents, and children who lose coverage due to age or marriage may continue their coverage for up to 36 months. COBRA allows temporary extension of benefits only.

ELECTING CONTINUATION OF VISION CARE COVERAGE AND PAYMENT REQUIREMENTS:

This form must be mailed within 60 days from the date it was received by the COBRA applicant to elect continuation of vision care coverage. After 60 days, the election period ends and eligibility ceases. To continue vision coverage through Vision Service Plan (VSP), monthly premium must be received by the 1st of each month. (i.e., April premium must be received by April 1st). Failure to pay premiums will result in the termination of coverage.

PAYMENT AGREEMENT:

❑ I elect to continue vision coverage at a rate of $____.___ per month. Premium may increase with employer's rate.

Do not include payment with this enrollment form. VSP will bill you directly once your enrollment form is processed.

NOTIFICATION AGREEMENT and SIGNATURES (Parent or Legal Guardian must sign if dependents are minor children):

I certify that I am not covered under any other group vision plan at this time. Should I become eligible under another group plan, I will notify VSP in writing to terminate my vision care coverage.

Signature of COBRA Applicant:	Date:

RETURN COMPLETED FORM TO: VISION SERVICE PLAN, CLIENT ADMIN SERVICES, MS 422 PO BOX 997100, SACRAMENTO, CA 95899-7100
QUESTIONS CALL: 800-400-4569

For Office Use Only

Group Name: State of Wisconsin	Agency:	Benefits Contact:	Signature:	Date Form was Provided:	Date Coverage Begins:	Date of Qualifying Event: