



**WISCONSIN
ELECTION OF CONTINUED VISION COVERAGE**

DESCRIPTION OF QUALIFYING EVENT:

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| <input type="checkbox"/> Disabled on the date of qualifying event | <input type="checkbox"/> Reduction of hours |
| <input type="checkbox"/> Legal separation or divorce | <input type="checkbox"/> Retiree |
| <input type="checkbox"/> Leave of absence – Dates from _____ to _____ | <input type="checkbox"/> Surviving Dependents |
| <input type="checkbox"/> Loss of child's dependent status | <input type="checkbox"/> Termination of employment |

COBRA APPLICANT INFORMATION:

Name of COBRA Applicant (Last, First, Middle Initial)	Daytime Telephone Number ()	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Mailing Address (Number, Street, City, State, ZIP)

Social Security Number	Birth Date (Month/Day/Year)	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
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CURRENT/FORMER EMPLOYEE INFORMATION:

Name of Employee	Social Security Number of Employee	Relationship to Applicant
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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
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
			<input type="checkbox"/> Male <input type="checkbox"/> 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.

PAYMENT REQUIREMENTS:

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.

ELECTING CONTINUATION OF VISION CARE COVERAGE:

This form must be mailed to Vision Service Plan 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.

PAYMENT AGREEMENT:

- I elect to continue vision coverage at a rate of \$ _____ per month. Premium may increase with employer's rate.
- Enclosed is my check for _____ months of coverage.
- My check for at least one month's premium will follow within 45 days of VSP's receipt of this form. Check will be applied RETROACTIVELY to effective date of coverage.

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:
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**RETURN COMPLETED FORM TO: Vision Service Plan , Client Admin Services, MS 229, P.O. 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:
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