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

HEALTH INSURANCE ELECTION FOR MILITARY SERVICE PERSONNEL

To: Employee or Designated Representative:

Employee Name	Employee Social Security Number

This Form Must Be Signed and Returned to the Payroll Representative Listed Below Regardless of Your Election

Section 40.05 (4g), Wis. Stat., provides additional months of state contribution toward health insurance premiums for certain military service personnel who receive a military leave of absence or are eligible for reemployment under Wis. Stat. § 321.64. To receive additional months of state contribution on the date of your activation, you must be:

1) insured under the State of Wisconsin Group Health Insurance plan and be receiving state contributions toward the premium, AND
2) a member of:
   - the Wisconsin National Guard,
   - a reserve component of the United States Armed Forces, or
   - be recalled to active duty (other than for training purposes) from inactive reserve status.

You or your designated representative may elect within 60 days after being activated to receive benefits resulting from this legislation and:

- Continue health insurance coverage indefinitely while on leave and establish pre-payment of premiums;
- Let your coverage lapse after being activated for military service due to non-payment of premium and reinstate coverage while on leave by filing a *Group Health Insurance Application/Change Form* (ET-2301);

  OR

- Allow your coverage to lapse and reapply within 30 days of return to employment (provided employment resumes within 180 days after release from active military service).

Please check all appropriate box(es) and sign below. ***All elections must be made within 60 days of activation.***

☐ 1. **I elect to continue State Group Health Insurance coverage**. I understand that if I continue coverage, I will receive my employer's share of any premium. I also understand that any employee share of the premium must be paid to my state agency to keep coverage in force.

☐ 2. **I elect not to continue State Group Health Insurance coverage**. I understand that by declining to continue coverage I do not receive my employer's share of the premium. I understand that by declining to continue coverage, I must return to active state employment in order to reenroll in State Group Health Insurance.

☐ 3. **I am terminating my State employment under § 321.64** and I elect to continue my health insurance coverage until I either return to work or active duty ceases.

☐ 4. **I let my State Group Health Insurance lapse effective _____ while on military leave and I elect to reinstate my coverage within 60 days of activation.** I elect to reinstate my health insurance to the health plan and coverage type that I was enrolled in at the time my State Group Health Insurance lapsed. I understand that coverage will be effective on the first of the month following my employer's receipt of the enclosed *Health Insurance Application/Change Form* (ET-2301) and that the employer's contribution will begin at that time. I understand that any employee share of the premium must be paid to my state agency to keep coverage in force.

Your election cannot go into effect unless this form is received by your employer within 60 days after you are activated. If you have any questions regarding your benefits under this legislation, please contact your payroll representative. Your payroll representative will return a photocopy of this form as an acknowledgment.

Date (MM/DD/CCYY)	Signature of Employee or Designated Representative	
Date (MM/DD/CCYY)	Signature of State Payroll Representative	EIN 69-036-0001-

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)

The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because 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. 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's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

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: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer 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, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

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：1-800-947-3529）

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)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: 1-800-947-3529).

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: 1-800-947-3529).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັ ຍ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

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: 1-800-947-3529).