Wisconsin Office of the
COMMISSIONER OF INSURANCE

Tony Evers, Governor of Wisconsin
Mark Afable, Commissioner of Insurance

Continuation Coverage election form if employer does not have a form available

Instructions: To elect continuation coverage, complete this Election Form and return it to us. Under Wis. Stat. § 632.897, you have 30 days after the date of this notice to decide whether you want to elect continuation coverage.

Send completed Election Form to: [*Enter Name and Address*]

This Election Form must be completed and returned by mail [*or describe other means of submission and due date*]. If mailed, it must be post-marked no later than [*enter date*].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting continuation coverage, your continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage in the [enter name of plan] (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a._____

[Add if appropriate: Coverage option(s): _____]

b. _____

[Add if appropriate: Coverage option(s): _____]

c. _____

[Add if appropriate: Coverage option(s): _____]

_____ _____

Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number

125 South Webster Street, P.O. Box 7873 | Madison, WI 53707-7873
p: 608-266-3585 | p: 1-800-236-8517 | f: 608-266-9935
ociinformation@wisconsin.gov | oci.wi.gov

[*Only use this model form if the plan permits Assistance Eligible Individuals to elect to enroll in coverage that is different than coverage in which the individual was enrolled at the time the qualifying event occurred.]*

Form for Switching Continuation Coverage Benefit Options

Instructions: To change the benefit option(s) for your continuation coverage to something different than what you had on the last day of coverage, complete this Form and return it to us. Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options.

Send completed Form to: *[Enter Name and Address]*

This Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*.

THIS IS NOT YOUR ELECTION NOTICE

YOU MUST SEPARATELY COMPLETE AND RETURN THE ELECTION NOTICE TO SECURE YOUR CONTINUATION COVERAGE.

I (We) would like to change the continuation coverage option(s) in the *[enter name of plan]* (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a._____

Old Coverage Option: _____

New Coverage Option: _____

b._____

Old Coverage Option: _____

New Coverage Option: _____

c._____

Old Coverage Option: _____

New Coverage Option: _____

_____ _____

Signature Date

_____ _____

Print Name Relationship to individual(s) listed above

_____

_____

_____ _____

Print Address Telephone number