



Wisconsin State Employees Dental and Excess Medical Coverage Continuation Form

Employer _____
Employee _____
Name and Address of Applicant _____
Phone No. of Applicant: _____

Group No. 3180
Employee Date of Birth _____
Social Security No. of Applicant _____
Applicant at left is: [] Employee*
[] Former Spouse* Birthdate _____
[] Dependent Child* Birthdate _____
* Insurance previously covered under customer number: _____

Annuitants have 30 days to apply for continuation as an annuitant.

For current benefit and premium information regarding this coverage call EPIC's Policyholder Services Department at 800-520-5750.

- [] I would like to elect continuation coverage (Complete entire form.)
[] I do not elect continuation coverage and understand that I will not be able to elect continuation in the future. (Date and sign bottom of form.)

Reason Continuation Elected (qualifying event):

- [] Employment Ended Date _____ [] Overage dependent Date _____
[] Divorce Date _____ [] Other Date _____

Length of Service as Wisconsin State Employee (needed to determine duration of continuation coverage):

- [] I have applied for a retirement annuity from the Wisconsin Retirement System (WRS) or I have 20 years of creditable service and I am eligible to apply for an immediate annuity, or I have 20 years of creditable service, am terminating state employment, and remain a WRS participant, or
[] I have less than 20 years of creditable service, and am terminating state employment.

Coverage to be continued: [] Single [] Two Person [] Family

The Dental and Excess Medical Coverage provided to you and, if elected, your family, may be continued upon your retirement or termination of eligibility for such coverage, as outlined by your employer. The first payment for continuation of coverage must be made within 45 days of the date you elect to continue coverage. Premium payments for continuation of coverage will be billed by EPIC and paid to EPIC.

Bill Statement by Mail: [] Annually [] Semi-Annually (\$2.00 fee) [] Quarterly (\$2.00 fee)

Electronic Fund Transfer: [] Semi-Annually EFT [] Quarterly EFT [] Monthly EFT

- [] Checking - Please include a voided check
[] Savings - Please provide: Account # _____ Routing # _____

*Billing statements are not provided when electronic fund transfer is selected.

DATE _____ SIGNATURE _____

This authorization will remain in effect until I notify the EPIC Life Insurance Company in writing of the termination or until the continuation period expires. My notification must allow The EPIC Life Insurance Company and my financial institution reasonable opportunity to discontinue the premium deduction.

PAYROLL ADMINISTRATORS USE ONLY:

Date form mailed to employee _____

Premium paid by payroll deduction through _____

- [] Voluntary Termination [] Involuntary Termination

(over for payment and application submission information) ->

Information and Instructions

If the person selecting group continuation coverage is not the group subscriber (the employee), a signed application must be included with this form. The application is located online at: <http://www.bussvc.wisc.edu/ecbs/epic-e11444-application.pdf> or you may contact your employer's benefits office for a paper application.

In order to continue coverage, you must submit this form and application, if applicable, within 60 days of the date on the enclosed notice or within 60 days of your coverage end date, whichever is later. Annuitants have 30 days from the coverage end date to apply for coverage as an annuitant. Coverage may be continued for up to 36 months for all continuants except retirees who may continue coverage indefinitely.

Do not include any money with this application. The EPIC Life Insurance Company will bill you directly.

Send completed form(s) to:

<p><u>If you did not</u> involuntarily terminate employment (e.g. you voluntarily resigned or retired) between September 1, 2008 and December 31, 2009 and/or you are not eligible for COBRA premium assistance, send completed forms(s) to:</p> <p>The EPIC Life Insurance Company P.O. Box 8430 Madison, WI 53708-8430</p>	<p>If you involuntarily terminated employment between September 1, 2008 and December 31, 2009 and/or you are applying for COBRA premium assistance, send completed forms(s) to:</p> <p>Your employer's benefits office</p>
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