**State Group Coverage Continuation Notice**

Today’s Date

Dear: Employee, Spouse and Dependent(s)’ Names

Your eligibility for group insurance coverage terminated on MM/DD/YYYY. You may have the right to continue the medical coverage you have now under the Group Policy if you have been continuously covered under the Employer Name group health plan for at least three months, and your coverage terminated due to one of the following events:

* An employee who experiences a reduction in hours and loses eligibility for coverage, along with the employee's spouse and dependents, if covered
* An employee who voluntarily or involuntarily loses eligibility for coverage other than discharge for misconduct, along with the employee's spouse and dependents, if covered
* A covered spouse and/or dependents of an employee who has died
* A former spouse whose coverage ends due to divorce or annulment

From the date of the qualifying event above, you have the right to continue coverage for up to 18 months.

In order to retain coverage under the Group Policy, you will be required to make monthly premium payments of $XXXX for yourself and/or any covered dependents. Payments should be submitted to: Employer Name and Address.

**You have 30 days from the date you are given notice of your continuation rights to make your decision and pay the required premium for coverage.**

You must submit the monthly premium before the first of each month to continue coverage without lapse. Employer Name will submit the premium to Health Insurance Carrier Name. For additional information about the State of Wisconsin’s Continuation Rights, please see the fact sheet included with this election form.

**Check One:**

* I DO elect to CONTINUE coverage under the Group Policy and agree to the conditions and requirements outlined above.
* I DO NOT elect to continue coverage under the Group Policy.

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Signature Date

*This template is a sample and should be reviewed by your employment attorney for completeness and accuracy.*







