

Department of Employee Trust Funds  
STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL

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**CHAPTER 4 — CHANGES TO COVERAGE AND TERMINATIONS**

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**401 Dual-Choice Enrollment**

Dual-Choice enrollment provides an annual opportunity for **currently insured subscribers** to change from one health plan to another, or change from single to family coverage without a waiting period for pre-existing medical conditions.

A. Enrollment Period

The Group Insurance Board sets the Dual-Choice Enrollment period, normally a three-week period in October. Changes in coverage take effect January 1 of the following year.

B. Enrollment Eligibility

Two requirements must be met to make a change during Dual-Choice:

1. Employee must be **currently insured** in the State Employee Group Health Insurance program; and
2. *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) must be received by the employer during the designated Dual-Choice Enrollment period.

C. Distribution of *It's Your Choice* booklets (ET-2301; Graduate Assistants, ET-2302)

The annual *It's Your Choice* booklet provides information on health insurance rates,

benefits, and plan availability and is forwarded to State agencies prior to the enrollment period for distribution to eligible employees (including those on leave of absence (LOA) and layoff). *It's Your Choice* booklets must be distributed in a timely manner to all insured employees, including employees who indicate they do not wish to make a change during Dual-Choice and employees on temporary layoff or LOA.

D. Employees Initially Eligible for Coverage on November 1 or December 1

Employees who are initially eligible for coverage on November 1 or December 1 and who wish to change to a different health plan or coverage type effective January 1, must file two applications during their regular enrollment period. The first application will cover the period from the date of initial coverage through December 31. The second application will change to whatever health plan or coverage type is selected effective January 1, and must have the "Dual-Choice" box checked as the reason for submitting the application.

E. Employee coverage ends after submitting a Dual-Choice Election.

- List current health plan on *Continuation - Conversion Notice* (ET-2311) if coverage ends prior to December 31.
- List Dual-Choice elected health plan on *Continuation - Conversion Notice* if current coverage ends on or after December 31.

F. Special January Reporting Instructions for Dual-Choice

1. Report in alphabetical order, the employees electing to switch health plans on the *Monthly Deletions Report* (ET-2612) for the health plan from which they are switching. (Refer to Subchapter 503 for instructions on completing the *Monthly Deletions Report*.)
2. Report in alphabetical order, the employees electing to switch health plans on the *Monthly Additions Report* (ET-2610) for the health plan to which they are switching. (Refer to Subchapter 502 for instructions on completing the *Monthly Additions Report*.)

## 402 Withdrawing Dual-Choice Elections

Employees may rescind Dual-Choice elections by notifying their employers in writing prior to December 31 of the same year. Upon receipt of the written request to rescind, employers must make four photocopies of the employer copy of the *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) initially submitted by the employee during Dual-Choice and write "Rescind" across each copy. Immediately forward one copy to the current health plan, one copy to the health plan indicated as the new health plan selected and one copy to ETF. Retain the last copy, along with the employee's written request to rescind, for the employer's records. Note: No application for coverage may be rescinded on or after the effective date of coverage. After the coverage effective date, the subscriber can only cancel the coverage or elect the standard plan w/180 day waiting period for pre-existing conditions. (See Subchapter 413.)

### 403 When a Health Plan is not Available at Dual-Choice

When a plan is no longer available for the upcoming year, subscribers enrolled in that plan must submit a *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) during the Dual-Choice Enrollment period to enroll in a new plan. Subscribers are notified by letter from the departing plan at the onset of Dual-Choice. Information on plans no longer available will also be included in the “Notable Plan and Program Changes” section in the *It’s Your Choice* booklet.

Note: In some instances—usually health plan mergers—applications are not required and subscribers are switched automatically to a new plan. In the event a new application is not required, Annual Dual-Choice *Employer Bulletins* and the *It’s Your Choice* booklet will include instructions.

Subscribers whose plan will no longer be available who fail to submit an application selecting an available plan during the Dual-Choice Enrollment period may only change to the Standard Plan to continue coverage. Coverage is effective the first day of the calendar month on or after the date the employer receives the application.

### 404 Late Dual-Choice Applications

Subscribers may request a review by ETF if they believe they were not offered a Dual-Choice opportunity and/or they feel that their *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) should be accepted after the designated Dual-Choice Enrollment period. The steps included in this process are as follows:

1. Employee submits application after end of Dual-Choice enrollment period.
2. Employer rejects and returns late application to employee with instructions on requesting a review. A sample letter informing an employee of this process is found in Subchapter 405.
3. Employee submits written request for review to the employer no later than January 31 following the Dual-Choice Enrollment period.
4. Employee includes in the written request the facts or circumstances of the review request including the remedy being sought.
5. Employer develops a cover memo addressed to ETF detailing the process used to distribute Dual-Choice materials to employees, the date of receipt of the employee’s Dual-Choice application, and any pertinent facts related to the employee’s review request.
6. Employer sends a **copy** of the employee’s Dual-Choice *Group Health Insurance Application*, the original letter of request for review from the employee, and the cover memo to:

DIVISION OF TRUST FINANCE & EMPLOYER SERVICES  
EMPLOYEE TRUST FUNDS

P O BOX 7931  
MADISON WI 53707-7931

7. ETF reviews the materials submitted and issues a letter within 60 days to the employee, copying the employer, approving or denying the request.

#### 405 Dual-Choice Review Sample Letter

Below is a sample letter from the employer informing an employee of the review process for a Dual-Choice application that is filed late.

(DATE)

(EMPLOYER NAME AND ADDRESS IF NOT ON THE LETTERHEAD)

Dear (EMPLOYEE NAME):

Your Dual-Choice health application is being returned to you by our office because it was not received timely. You may request a review of your late application by the Department of Employee Trust Funds through the following process:

- Prepare a written request detailing the circumstances and facts surrounding the reason for your late application and the remedy being sought.
- **Submit your written request to our office at the address noted above by January 31.** Do not submit your request directly to the Department of Employee Trust Funds.
- We will review your request for completeness and attach any pertinent supporting documentation.
- We will submit your request, your health application, and other supporting documentation to the Department of Employee Trust Funds for review.
- The Department of Employee Trust Funds will review the materials and issue you a letter approving or denying the request.

If you have questions, please contact (NAME) at (TELEPHONE NUMBER).

#### 406 Switching Health Plans Following Residential Move

A subscriber who has a residential move to another county for a minimum of three months has an enrollment opportunity to switch health plans, even if the current health plan remains available in the county to which the subscriber moved. (A move from one medical facility to another medical facility by the subscriber is not considered a residential move.) To change health plans, the relocating subscriber must submit a *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) to the employer within

30 days after the move. The coverage effective date for the new plan is the 1<sup>st</sup> of the month following the employer's receipt of the application.

If the relocating subscriber wants to change health plans and does not submit an application within 30 days after the move, the subscriber and all covered dependents can submit a late application but are limited to the Standard Plan with a 180-day waiting period for pre-existing conditions. The subscriber may change health plans during the next Dual-Choice Enrollment period.

If the relocating subscriber wants to remain with the same health plan, the subscriber should complete the *Health Insurance Information Change* form (ET-2329) indicating the residential address change. (Refer to Subchapter 409.)

#### **407 Adding Dependents**

A dependent may become eligible due to marriage, birth, adoption or placement for adoption, or regaining eligibility status and may be added to current coverage. (Submit documentation for additions due to adoption.)

- A subscriber enrolled in single coverage may add a newly eligible dependent by submitting to the employer a completed *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302). Coverage is effective on the date of birth, adoption, placement for adoption, or marriage if the application is submitted within 60 days of the birth, adoption or placement for adoption, or within 30 days of a marriage. A full month's premium for family coverage is due for that month if family coverage is effective before the 16<sup>th</sup> of the month. Otherwise the family premium amount goes into effect for the following month.
- A subscriber enrolled in family coverage must add a newly eligible dependent by submitting to the employer a *Health Insurance Information Change* form (ET-2329). The form should be submitted within 60 days of the birth, adoption or placement for adoption, or within 30 days of a marriage.
- A subscriber can add a previously ineligible dependent who regains eligibility. To add the dependent, a subscriber enrolled in single coverage must submit to the employer a *Group Health Insurance Application* and a subscriber enrolled in family coverage must submit a *Health Insurance Information Change* form. The application or change form must be submitted within 30 days of the dependent regaining eligibility with coverage effective the date eligibility was regained.

#### **408 Deleting Dependents**

Dependent children lose eligibility for reasons such as reaching a certain age (i.e., age 25, or age 19 and not a full-time student), full-time student status ceasing, marriage, and ceasing to be dependent on either parent or guardian for support and maintenance. A spouse and stepchildren lose eligibility due to divorce. To ensure the right to continuation coverage is not lost, a loss of eligibility must be reported to the employer within 60 days

of the later of (1) the event that caused the loss of coverage, or (2) the end of coverage. (Refer to Chapter 6 for information on continuation and conversion coverage.)

- A subscriber who continues to be eligible for family coverage (i.e., has remaining eligible dependents) must submit to the employer a *Health Insurance Information Change* form (ET-2319) deleting the ineligible dependent.

**NOTE: Employers should verify there are remaining eligible dependents upon receipt of the change form. If there are none, the employer should reject the change form and provide the subscriber with a *Group Health Insurance Application* for completion, changing from family to single coverage.**

- A subscriber who no longer has eligible dependents must submit to the employer a completed *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) changing from family to single coverage. The change in coverage will be effective the first of the month following the loss of eligibility, except in the case of divorce or as determined by ETF in unique situations. (Refer to Subchapter 603 for information about divorce.)

#### 409 Completing the *Health Insurance Information Change Form* (ET-2329)

Both the employee and employer have a role in completing the *Health Insurance Information Change* form (ET-2329). (A sample follows this subsection.)

##### A. Employee

Complete Sections 1 through 5 of the form and return it to employer:

- Section 1 must be completed.
- Section 2 must be completed only when the subscriber is reporting one or more of the following changes:
  - Name change
  - Address change
  - Home or daytime phone number change
  - Adding the social security number for a dependent
  - Changing the selected physician or clinic
  - Updating information about other insurance coverage
- Section 3 must be completed only when **adding** a dependent and documentation attached where specified.
- Section 4 must be completed only when **deleting** a dependent.
- Section 5 must be completed.

##### B. Employer

- Upon receipt of this form, verify that the subscriber sections are completed appropriately and supporting documentation is attached when indicated.
- Complete the bottom section of the form ensuring codes entered are consistent with most recent forms filed:
  - a. Employee Type - Enter the appropriate code. (Refer to subchapter 1103.)
  - b. Coverage Code - Coverage code identifying single or family coverage. (Refer to subchapter 1102.)
  - c. Carrier Suffix - Two-digit code identifying the carrier (health plan). It is sometimes referred to as the carrier code or plan suffix code. (Refer to the *Monthly Coverage Report* for the plan suffix codes.)
  - d. Participant County – Code identifying the county in which the subscriber resides. (Refer to subchapter 1101.)
  - e. Physician County - code identifying the county in which the subscriber's selected physician or clinic is located. (Refer to subchapter 1101.)
  - f. Program Option Code – LOCAL GOVERNMENT EMPLOYERS ONLY
  - g. Surcharge Code – LOCAL GOVERNMENT EMPLOYERS ONLY
  - h. Name of Employer.
  - i. Employer Number - The employer identification number (EIN) given to employers, beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**0001-101**).
  - j. Five-digit Group Number - The five digit number assigned to State agencies (e.g., **84535**).
  - k. Date Received by Employer - The month, day and year the employer received the completed form. It is important this date be accurate in order to determine eligibility for continuation.
  - l. Monthly Employee Share - The amount the employee contributes toward the monthly premium for the health plan selected. (Refer to subchapter 302.)
  - m. Monthly Employer Share. The amount the employer contributes toward the monthly premium for the health plan selected. (Refer to subchapter 302.)
  - n. Date Employment Began - The month, day and year the employee began employment with the employer. For rehired employees, enter the rehire date.
  - o. Event Date - The month, day and year of the event which is the reason for submitting the form.
  - p. Prospective Date of Coverage - The month, day and year the change in coverage should be effective.
  - q. Payroll Representative Signature acknowledging the employer received and audited the form.
  - r. Telephone number of the employer representative who signed the form.
- Retain the employer copy and give the employee copy to the employee.
- Immediately send the Carrier copy directly to the health plan and the ETF copy to ETF.

410

Health Insurance Information Change Form (ET-2329)

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

**HEALTH INSURANCE INFORMATION CHANGE**

This form is to be completed by a subscriber who is only revising relevant information. Transactions such as changing HMOs or changing from single to family coverage require a new health application (ET-2301) and should not be submitted on this form.

**SUBSCRIBER:** Complete Sections 1-5. Return form to employer (or ETF if an annuitant).

1. Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Health Insurance Plan \_\_\_\_\_ Present Coverage:  Single  Family  
 Subscriber # \_\_\_\_\_ Group # \_\_\_\_\_

*(If retiree or continuant)*

I was a dependent or spouse of (name): \_\_\_\_\_ Social Security Number \_\_\_\_\_

2. Check the box(es) indicating the type(s) of change(s): Event Date \_\_\_\_\_  
 Name change (list former name) \_\_\_\_\_  
 Address change to: Street: \_\_\_\_\_  
 County \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone # \_\_\_\_\_  Daytime Telephone # \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ for \_\_\_\_\_  
 Selected physician or clinic change to: \_\_\_\_\_ for \_\_\_\_\_  
 Change in subscriber's physician or clinic county?  No  Yes, county is \_\_\_\_\_  
 Update other insurance coverage for: \_\_\_\_\_  
 Through State of WI, including University of WI?  No  Yes Name of Insured \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Name of Employer \_\_\_\_\_  
 Group # \_\_\_\_\_ Subscriber/Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_ Medicare?  No  Yes

3. Complete the following when **adding** a dependent, please list the event date in the grid below (*applicant relationship code on reverse side*):  
 Reason:  Marriage  Student Status Changed  Birth  Legal Ward\*  Adoption\*  Disabled  
 \*Please attach documentation for additions due to legal ward or adoption status  
 Is spouse State of WI employee, including University of WI?  Yes  No

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Applicant Rel. Code	Selected Physician or Clinic		Event Date
			Mo	Da	Yr				Last Name	First	

Dependents include spouse and children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

4. Complete the following for **deleting** a dependent. Please list the event date in the grid below:  
*[Do not use this form to remove last dependent. Please complete new health application (ET-2301) to change to single coverage.]*  
 Reason:  Divorce  Age\*  Dependent Married  Student Status Changed  Other \_\_\_\_\_  
 \*Dependent turned 19 and is not a full-time student; full-time student turned 25; grandchild of a dependent that turned 18.

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Event Date	Dependent's Address (if different than subscriber's)	NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT.
			Mo	Da	Yr					

5. I have read and understand the Terms and Conditions on the reverse side.  
 Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

EMPLOYER COMPLETES AREA BELOW Coding Instructions are in the Employer Health Insurance Manual							
Enrollment Type <b>65</b>	Employee Type	Coverage Code	Carrier Suffix	Participant County	Physician County	Program Option Code	Surcharge Code
Name of Employer				Employer Number <b>69-036-</b>	Group Number	Date Received by Employer (MM/DD/CCYY)	
Monthly Employee Share \$	Monthly Employer Share \$	Date Employment Began (MM/DD/CCYY)		Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)	
Payroll Representative Signature					Telephone ( )		

## 411 Terminating Coverage

Active coverage may be terminated for an employee in a variety of situations. **Employees terminating coverage must be reported on the *Monthly Deletions Report* (ET-2612) deleting the employee from active status and on the *Monthly Coverage Report*.** (Refer to Subchapter 503 for instructions on completing the *Monthly Deletions Report* and Subchapter 505 on completing the *Monthly Coverage Report*.)

### Termination/Deletion Situations

Activity/ Transaction	Effective Date	Form(s) Required (in addition to reporting the termination of the Monthly Deletions Report (ET-2612) and the Monthly Coverage Report (ET-1607).	Adjustments/Refunds/ Comments
LEAVE OF ABSENCE - MILITARY	The last day of the month for which premiums are paid.		Employee may request refund of any premiums paid in advance by writing to the employer. The employer must receive the request on or before the last day of coverage to be eligible for a refund of the future month's premiums.
EMPLOYEE TERMINATION (FOR CONTINUATION, SEE CHAPTER 6)	Covered as far as premiums have been paid.	<i>Continuation - Conversion Notice</i> (ET-2311)	Terminated employee is eligible for continuation or conversion if application is made to ETF within 60 days of the date of notice or within 60 days after coverage ends, whichever is later.
DEATH OF EMPLOYEE - SINGLE COVERAGE	Date death occurred.		Refund any premiums paid in advance for coverage beyond the end of the month in which death occurred.
DEATH OF EMPLOYEE - FAMILY COVERAGE	Coverage under the employee's contract continues through the last day of the month of the employee's death. Continuation coverage, if elected, is effective the 1 <sup>st</sup> of the month following the date of death.	<i>Continuation - Conversion Notice</i>	Do not refund any premiums unless authorized by ETF.

**Termination/Deletion Situations**

Activity/ Transaction	Effective Date	Form(s) Required (in addition to reporting the termination of the Monthly Deletions Report (ET-2612) and the Monthly Coverage Report (ET-1607).	Adjustments/Refunds/ Comments
CANCELLATION OF COVERAGE	Coverage continues through the last day of the month in which the employer receives the cancellation application or a later date (end of a month) specified on the cancellation.	<i>Group Health Insurance Application</i> (ET-2301; Graduate Assistants, ET-2302)	Employee must request a refund of premium in writing. The employer must receive the request on or before the last day of the coverage, in order for the employee to receive a refund for the following month. The request must be received on or before the last workday of the month.
LEAVE OF ABSENCE – PREMIUMS NOT PREPAID	Coverage continues through the last day of the month for which premiums have been paid.		Shown as deletion on following month's report.
APPEAL OF DISMISSAL – DELETION FOR EMPLOYEE CHOOSING NOT TO CONTINUE COVERAGE DURING APPEAL.	Coverage continues through the last day of the month for which premiums have been paid.		<p>Employees appealing dismissals may prepay premiums to the employer (without employer share) prior to a decision and are not deleted from coverage. If appeal is decided in employee's favor (employee is made whole), the employer share for those months prepaid is to be refunded. (Refer to Subchapter 315)</p> <p>Premium payments must be received at least 30 days prior to the coverage month.</p>
RETIREMENT –	Coverage is continued without lapse upon retirement if an employee retires with an immediate annuity.*	<i>Accumulated Leave Certification</i> (ET-4306)	ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs.

### Termination/Deletion Situations

Activity/ Transaction	Effective Date	Form(s) Required (in addition to reporting the termination of the Monthly Deletions Report (ET-2612) and the Monthly Coverage Report (ET-1607).	Adjustments/Refunds/ Comments
TRANSFER BETWEEN SPOUSES, OR HEALTH PLANS	Coordinate transfer date so no duplication or lapse in coverage occurs.	<i>Group Health Insurance Application</i>	Coordinate effective dates on the monthly reports with other spouse or health plan.
DIVORCED SPOUSE	The later of the end of the month that employer provides <i>Continuation - Conversion Notice</i> or the end of the month in which the divorce is entered. (Refer to Chapter 6).	<i>Continuation - Conversion Notice and Group Health Insurance Application</i>	Coverage for stepchildren also ends. Divorced spouse and stepchildren are eligible for continuation or conversion if application is made no later than 60 days from the termination of their coverage or within 60 days of the date they were notified by their employer, whichever is later.
GRANDCHILD	End of the month in which parent turns age 18	<i>Continuation - Conversion Notice and Group Health Insurance Application</i>	Grandchild is eligible for continuation or conversion if application is made to ETF within 60 days of the date of notice or with 60 days after coverage ends, whichever is later.

\*This requirement is waived for employees who terminate after age 55 (age 50 if in a protective occupation) with at least 20 years of WRS creditable service and who do not begin an immediate annuity. An immediate annuity begins within 30 days of termination of employment.

## 412 Changing from Active to Annuitant Coverage

Retiring insured employees are eligible to continue health coverage under any of the following conditions: (Refer to Chapter 7)

- Employee receives an immediate annuity upon retirement (monthly or lump sum benefit), WRS disability, or Long-Term Disability Insurance benefit.
- Employee terminates after age 55 (50 for protective category employees) with at least 20 years of creditable WRS service, but does not take an immediate retirement annuity.

When an employee retires, the employer must report it on the *Monthly Deletions Report* (ET-2612) deleting the employee from active status and on the *Monthly Coverage Report*

(ET-1607). (Refer to Subchapter 503 for instructions on completing the *Monthly Deletions Report* and Subchapter 505 on completing the *Monthly Coverage Report*.)

#### 413 Voluntarily Canceling Coverage

A subscriber can voluntarily cancel coverage at any time by submitting a *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) to the employer and checking “Cancellation” as the reason for submitting the application. The cancellation will be effective the last day of the month in which the employer receives the application or a later date as specified on the cancellation notice. Voluntary cancellation of coverage does not provide the employee and dependents an opportunity for continuation or conversion of the group health insurance coverage (described in Chapter 6).

The employer must report the cancellation on the appropriate month’s *Monthly Deletions Report* (ET-2612) and the *Monthly Coverage Report*. Under no circumstances is a partial month’s premium refunded.

#### 414 Enrollment/Coverage Change Effective Date Reference Chart

SITUATION	FORMS REQUIRED AND DUE DATE (IF APPLICABLE)	EFFECTIVE DATE OF COVERAGE (AND/OR CHANGE)
DUAL-CHOICE	Application due during the annual Dual-Choice Enrollment period as described in Subchapter 401.	January 1 of the following year.
MARITAL STATUS CHANGE	<p>1. <i>Group Health Insurance Application</i> (ET-2301; Graduate Assistants, ET-2302) (if changing from single to family coverage).; or</p> <p>2. <i>Health Insurance Information Change</i> (ET-2329) form (if no change in coverage)</p> <p>Either form is due within 30 days after marriage or divorce, and within 60 days of a death of a dependent. Be sure to indicate the date of occurrence in the "Event Date" box.</p>	<ul style="list-style-type: none"> <li>• For an employee who is first becoming eligible for family coverage because of marriage, coverage becomes effective the date of marriage.</li> <li>• For divorce, spouse's and stepchildren coverage ceases at the end of the month in which the divorce is granted/entered or the end of the month that employer provides <i>Continuation - Conversion Notice</i> (ET-2311), whichever is later.</li> <li>• For widow(er), the change is effective at the end of the month in which the death occurred. See Chapter 6 on continuing coverage in divorce and surviving spouse situations.</li> </ul>

SITUATION	FORMS REQUIRED AND DUE DATE (IF APPLICABLE)	EFFECTIVE DATE OF COVERAGE (AND/OR CHANGE)
<p>INITIAL ENROLLMENT OF SUBSCRIBER INCLUDES DEPENDENT (Spouse, dependent child, dependent child and full-time student over age 19, unmarried child with a physical or mental disability who is incapable of self-support)</p>	<p>1. <i>Group Health Insurance Application</i> Dependent child over age 19 is listed as full-time student on enrollment application.</p> <p>2. No other documentation supporting student status is required at the time of enrollment.</p> <p>3. Due date determined by subscribers' eligibility.</p>	<p>Same date subscriber's coverage begins.</p>
<p>MOVE TO ANOTHER COUNTY FOR A MINIMUM OF 3 MONTHS</p>	<p><i>Group Health Insurance Application</i> due within 30 days after subscriber's relocation to another county.</p>	<p>First of the month following employer's receipt of application. Effective date can not be prior to event date. This is a change in health plan only. There are no waiting periods for pre-existing conditions. The level of coverage can change only if a qualifying event (i.e., birth, marriage, etc.) accompanies the relocation.</p>
<p>VOLUNTARY CHANGE TO SINGLE COVERAGE</p>	<p><i>Group Health Insurance Application</i> due within 30 days of change.</p>	<p>Effective first of the month following receipt of application by the employer. Voluntary cancellation is not considered a "qualifying event" for dependent continuation coverage.</p>
<p>CHANGE TO FAMILY COVERAGE</p>	<p>If first becoming eligible for family coverage, or if already eligible for family coverage but single coverage is in effect, a <i>Group Health Insurance Application</i> is due within 30 days of marriage or within 60 days of the birth, adoption, or placement for adoption. Be sure to indicate the event date. Other documentation proving guardianship, adoption, or paternity is required.</p>	<p>The date the change in family status occurred.</p> <p>If the application is submitted after the enrollment period, change to family coverage is available only under the Standard Plan and a 180-day waiting period for pre-existing conditions applies to the spouse and/or dependent children.</p>

SITUATION	FORMS REQUIRED AND DUE DATE (IF APPLICABLE)	EFFECTIVE DATE OF COVERAGE (AND/OR CHANGE)
COVERAGE LAPSED DURING LEAVE OF ABSENCE	<i>Group Health Insurance Application</i> is due within 30 days after returning to work.	Reinstate the same level of coverage through the health plan in effect prior to the leave with coverage becoming effective the first of the month on or following the employer's receipt of the application. If the leave encompassed the <b>entire</b> Dual-Choice Enrollment period, the subscriber is eligible for a Dual-Choice election.
REINSTATEMENT AFTER COMPLETION OF ACTIVE MILITARY SERVICE	<i>Group Health Insurance Application</i> due within 30 days of return to employment. Must have had coverage prior to entry in military—unless a qualifying event occurred—and return to work within 180 days of release from active military service.	The level of coverage for the health plan in effect at the time of the military leave will become effective on the date of reinstatement. In the event the subscriber is on leave during the entire Dual-Choice Enrollment period, the subscriber will be given a Dual-Choice enrollment opportunity. (Employee may change coverage level if a qualifying event occurred while on military leave.)
STANDARD PLAN	<i>Group Health Insurance Application</i> due anytime.	Employees can select the Standard Plan at anytime with coverage effective the first of the month following the employer's receipt of the application. Coverage will be subject to a 180-day waiting period for pre-existing conditions.
LOSS OF OTHER COVERAGE, INCLUDING EMPLOYEE WHO LOSES ELIGIBILITY FOR MEDICAL ASSISTANCE	<i>Group Health Insurance Application</i> due within 30 days of loss of eligibility for other coverage. Application must be accompanied by documentation that includes date the coverage is lost.	The effective date is the day following the termination date of the former policy. Employee should be reported on the next monthly reports with adjustments, if applicable. If coverage begins after the 15th of the month, the premium is waived for that month. In all other cases, a full month's premium is due.

SITUATION	FORMS REQUIRED AND DUE DATE (IF APPLICABLE)	EFFECTIVE DATE OF COVERAGE (AND/OR CHANGE)
COMBINING TWO STATE SINGLE CONTRACTS TO MAKE A FAMILY CONTRACT OR SPLITTING A FAMILY CONTRACT INTO TWO SINGLE CONTRACTS. THIS IS NOT A SPOUSE TO SPOUSE TRANSFER.	Group Health Insurance Application . There is no applicable due date. A family contract split into two single contracts or two single contracts combined into one family can be done at any time.	The effective date of coverage is the first of the month following receipt of the application by the employer in both cases. When splitting a family contract into two single contracts, the health plan must remain the same as under the family contract. When combining two single contracts into one family contract, the health plan selected must have been on one of the single contracts.
<b>ADDING A DEPENDENT</b>		
ADDING A DEPENDENT	<p>1. <i>Group Health Insurance Application</i> (if changing from single to family coverage).; or</p> <p>2. <i>Health Insurance Information Change</i> form (if no change in coverage).</p> <p>Either form is due within 60 days of date of birth, adoption or placement for adoption. Documentation of adoption or placement for adoption must be provided.</p>	Date of birth or date child is adopted or placed for adoption.
<b>PROSPECTIVELY</b> ADDING STUDENT DEPENDENT WHO WAS NOT PREVIOUSLY COVERED ON SUBSCRIBER'S CONTRACT TO EXISTING CONTRACT	<p>1. <i>Health Insurance Information Change</i> if subscriber currently has family coverage.</p> <p>2. <i>Group Health Insurance Application</i> for single coverage changing to family coverage.</p> <p>Either form due within 30 days of uninsured dependent's enrollment (date classes begin) as full-time student.</p> <p>(Note: Dependent must be unmarried and otherwise eligible; i.e., meet support and maintenance requirements.)</p> <p>No other documentation supporting student status is required at the time of this enrollment.</p>	<p>If within 30 days, coverage is effective the date eligibility was regained.</p> <p>After 30 days following student enrollment if family coverage is in place, the dependent coverage becomes retroactive and documentation of student status is required.</p> <p>After 30 days following student enrollment if changing from single to family coverage, changing to the standard plan w/180 day waiting period for pre-existing conditions prospectively is the only alternative.</p>

SITUATION	FORMS REQUIRED AND DUE DATE (IF APPLICABLE)	EFFECTIVE DATE OF COVERAGE (AND/OR CHANGE)
<p><b><u>PROSPECTIVELY</u></b>            ADDING A PREVIOUSLY COVERED DEPENDENT TO EXISTING CONTRACT</p>	<p>1. <i>Health Insurance Information Change</i> if subscriber currently has family coverage.</p> <p>2. <i>Group Health Insurance Application</i> for single coverage changing to family coverage.</p> <p>Either form due within 30 days of uninsured dependent's enrollment (date classes begin) as full-time student. (Note: Dependent must be unmarried and otherwise eligible; i.e., meet support and maintenance requirements.) No other documentation supporting student status is required at the time of this enrollment.</p>	<p>If within 30 days, coverage is effective the date eligibility was regained.</p> <p>After 30 days following student enrollment if family coverage is in place, the dependent coverage becomes retroactive active coverage and documentation of student status is required.</p> <p>After 30 days following student enrollment if changing from single to family coverage, changing to the standard plan w/180 day waiting period for pre-existing conditions prospectively is the only alternative.</p>
<p>DEPENDENT CHILD TERMINATED FROM SUBSCRIBER'S FAMILY CONTRACT WHEN PLAN FAILS TO RECEIVE STUDENT STATUS LETTER RESPONSE</p>	<p>1. <i>Health Insurance Information Change</i> AND</p> <p>2. <u>one</u> form of documentation of student status</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Completed student status letter</li> <li>• Letter from educational institution showing full-time student status</li> <li>• Current semester class schedule, or</li> <li>• Copy of tuition payment receipt showing full-time status.</li> </ul> <p>There is no due date for these forms; ideally, the forms should be submitted as soon as the subscriber is aware of the termination of the dependent's coverage.</p>	<p>Coverage is re-established back to the date of termination.</p>

SITUATION	FORMS REQUIRED AND DUE DATE (IF APPLICABLE)	EFFECTIVE DATE OF COVERAGE (AND/OR CHANGE)
<p><b><u>RETROACTIVELY.</u></b>            ADDING PREVIOUSLY COVERED DEPENDENT, WHO SHOULD NOT HAVE BEEN TERMINATED FROM CONTRACT, TO EXISTING CONTRACT</p> <p>SUBSCRIBER CLAIMS DEPENDENT COVERAGE WAS TERMINATED IN ERROR and DEPENDENT NEVER LOST FULL-TIME STUDENT STATUS.</p>	<p>1. <i>Health Insurance Information Change</i> using date retroactive to the date coverage was terminated</p> <p>AND</p> <p>2. One form of documentation supporting student status</p> <p>Examples:</p> <ul style="list-style-type: none"> <li>• Completed student status letter</li> <li>• Letter from educational institution showing full-time student status</li> <li>• Current semester class schedule, or</li> <li>• Copy of tuition payment receipt showing full-time status.</li> </ul> <p>There is no due date for these forms; ideally, the forms should be submitted as soon as the subscriber is aware of the termination of the dependent's coverage.</p>	<p>Coverage is re-established back to the date of termination.</p>
<p>SINGLE CONTRACT IN EFFECT, NO ELIGIBLE DEPENDENTS – DEPENDENT REGAINS ELIGIBILITY DUE TO FULL-TIME STUDENT STATUS</p>	<p><i>Group Health Insurance Application</i> due within 30 days of uninsured dependent's enrollment (date classes begin) as full-time student. (Note: Dependent must be otherwise eligible; i.e., meet support and maintenance requirements and be unmarried.)</p>	<p>Family coverage is effective the date of enrollment (date classes begin) as full-time student if completed application is received within 30 days.</p> <p>After 30 days following student enrollment if changing from single to family coverage, changing to the standard plan w/180 day waiting period for pre-existing conditions prospectively is the only alternative.</p>