



# State Health Insurance

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## **EMPLOYER**

## **ADMINISTRATION**

## **MANUAL**

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Wisconsin Department of Employee Trust Funds  
801 West Badger Road  
Madison, WI 53702

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**PREFACE**

The *State Agency Health Insurance Administration Manual* (ET-1118) is a reference source intended to aid your administration of, and participation in, the Wisconsin State Employee Group Health Insurance program. Its contents are based on state statute, administrative code, and group health contract language and contain instruction relevant to the administrative and reporting practices of the Group Health Insurance program. Wisconsin statutes, administrative code, and group health contract language are reviewed on an ongoing basis and may be revised after the printing of this manual. The Department of Employee Trust Funds (ETF) will make every effort to communicate changes to employers via *Employer Bulletins* and manual updates. This manual contains examples relevant to the administration of the Group Health Insurance program but may not cover every eventuality. Specific program questions and situations will be considered with regard to current statute, administrative code, *Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program* (ET-1136) and/or case law by ETF.

Consult this manual as a first-step resource when you encounter Group Health Insurance program-related questions or concerns. If questions remain, contact the Employer Communication Center. The Employer Communication Center provides a single point of contact to resolve issues regarding eligibility, enrollment, coverage, and reporting for ETF benefit programs. A central voicemail system handles calls when all Employer Communication Center staff lines are busy. The voicemail system is monitored on a regular basis and all calls are returned within 24 business hours. The Employer Communication Center telephone numbers are (608) 264-7900 and toll-free 1-888-681-3952.

Your efforts to accurately administer the provisions of the Group Health Insurance program are appreciated. If you have comments on this edition or suggestions for the next edition of this manual, please contact the **Employer Communication Center at (608) 264-7900 or toll-free at 1-888-681-3952.**

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**101 Introduction**

The Wisconsin State Employee Group Health Insurance program is authorized by Wis. Stat. § 40.51 and is administered under the authority of the State of Wisconsin Group Insurance Board. The program offers employees the opportunity to choose between two or more health plans, including the Standard Plan available to all employees in all counties and alternate health plans (i.e., HMOs) having provider networks in specific geographic areas of the state.

**102 Employer Responsibilities**

Designate a health insurance representative to:

- Explain eligibility, cost, enrollment procedures, and effective dates to employees;
- Provide *It's Your Choice* (ET-2107; Graduate Assistants, ET-2127) booklets to all new subscribers and to all current subscribers prior to annual Dual-Choice Enrollment period;
- Provide information when applicable on Medicare, Dual-Choice enrollment, and continuation-conversion provisions;
- Secure, audit and maintain health insurance applications and arrange payroll deductions;
- Submit health insurance applications and other forms to ETF and health plans in a timely manner;
- Prepare, audit and submit monthly remittance reports to ETF;
- Refer employees to the appropriate health plan contact for claim or benefit questions;

- Refer annuitant health insurance questions to ETF Benefit Payment Services Section;
- Refer contractual interpretation questions to ETF (Refer to Subchapter 107.);
- Respond to health plan questions and audits in a timely manner;
- Maintain a supply of current ETF forms.

### **103 Health Insurance Portability and Accountability Act (HIPAA)**

HIPAA is a federal law that supersedes or preempts state law under certain conditions. As a covered entity, ETF must comply with the following applicable HIPAA regulations:

- **HIPAA/Pre-Existing Conditions:** Federal HIPAA is intended to make it easier for employees to change jobs by limiting waiting periods for coverage of pre-existing health conditions.

Under the Group Health Insurance program, employees who fail to enroll for coverage when first offered but elect to enroll later, are limited to coverage under the Standard Plan with a 180-day waiting period for pre-existing conditions. There are certain situations where the employee may enroll late without this restriction, such as loss of other group coverage, marriage and birth or adoption of a child.

- **HIPAA/Privacy, Electronic Transactions Standards and Security:** HIPAA's administrative simplification rules are intended to simplify and streamline healthcare claims and payment processes through the implementation of national standards. The rules also require that health information be protected from unauthorized use or disclosure. The three components of the rules are privacy, electronic data transaction standards, and security. The privacy rule, first effective April 14, 2003, established limits on how health information can be used and disclosed. The transaction standards rule, first effective October 16, 2003, set out uniform methods for conducting electronic transactions. The security rule, first effective April 21, 2005, requires safeguards for health information maintained in electronic form.
- A Notice of Privacy Practices is posted on ETF's Web site (<http://etf.wi.gov>) and appears in Section B of the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127).
- Questions about HIPAA may be directed to ETF's Privacy Officer at 1-877-533-5020.

### **104 ETF Ombudsperson Services**

ETF offers ombudsperson services to assist subscribers who remain dissatisfied after first contacting the health plan regarding a problem or complaint. Employers should direct employees in this situation to write or telephone ETF's ombudsperson at:

Department of Employee Trust Funds  
P O Box 7931  
Madison WI 53707-7931  
Local Intake Line (Madison) 608-261-7947  
Toll Free 1-877-533-5020 ext. 17947  
e-mail [ombudsperson@etf.state.wi.us](mailto:ombudsperson@etf.state.wi.us)

ETF ombudspersons advocate for subscribers and attempt to resolve complaints and problems on their behalf. If unsuccessful, the ombudsperson advises the subscriber of subsequent avenues of appeal. Complaints should be made in writing using the *Insurance Complaint* form (ET-2405) whenever possible. Additional information regarding ETF ombudsperson services can be found on the ETF Web site (<http://etf.wi.gov>) under the “Members” section.

Note: For complaints pertaining to benefit determinations, subscribers must complete at least the first level of the administrative review process through the health plan prior to requesting assistance from the ETF ombudsperson.



**106 Internet Address – <http://etf.wi.gov>**

ETF maintains an Internet site with information on various benefit topics of interest to employers, active/inactive members, and retirees. The site contains numerous forms and brochures, maps to our offices, hot topics, a form for submitting e-mail inquiries, past and present *Employer Bulletins*, and a benefit calculator. The site provides links to related sites such as the Pharmacy Benefit Manager (PBM), State of Wisconsin Investment Board, Social Security Administration, and Internal Revenue Service.

**107 Administrative Offices**

<b>MADISON</b>	
<b>Office:</b>	Department of Employee Trust Funds 801 W. Badger Road Madison WI 53702
<b>Mailing Address:</b>	P O Box 7931 Madison WI 53707-7931
<b>Telephone:</b>	Employers: 1-608-264-7900 Or toll-free 1-888-681-3952 Employees: 1-877-533-5020 (toll free) 266-3285 (local)
<b>TTY:</b>	(608) 267-0676
<b>FAX:</b>	(608) 266-5801
<b>Web Site:</b>	<a href="http://etf.wi.gov">http://etf.wi.gov</a>
<b>OFFICE HOURS:</b>	
7:45 a.m. to 4:30 p.m. Monday through Friday (except holidays)	
<b>PHARMACY BENEFIT MANAGER (PBM) CONTACT INFORMATION</b>	
Navitus Health Solutions 5 Innovation Court, Suite B Appleton WI 54914 1-866-333-2757 (toll free) Fax: 1-920-225-7002 <a href="http://www.navitus.com">www.navitus.com</a>	

**108 Employer Forms**

Employers have several options for ordering ETF forms and brochures. Employers may use our voice mail request line in Supply and Mail Services at (608) 266-3302. The voice mail program allows you to call and order forms and brochures by leaving a

recorded message. The message will prompt you to provide the following:

- Employer name.
- Employer telephone number.
- Seven-digit employer identification number (EIN) preceded by 69-036-.
- Employer mailing address.
- Four-digit form number beginning with the letters ET- (for example, ET-2405).
- Name of the form (for example, *Insurance Complaint* form).
- Quantity desired.

The message also will state the amount of time you should allow for your order to be filled.

Employers can also order their forms and brochures online at ETF's Web site (<http://etf.wi.gov>) under the "Employers" section.

Orders are generally filled within one to three weeks. Response time depends on the number of requests received, staffing levels and other workload demands. If you do not receive an order within three weeks, please call the request line to check the order's status. State the following:

- The date the order first was placed.
- Your employer name, your name, and telephone number.

Your call will be returned as soon as possible, informing you of the status of your order.

It is sometimes necessary to partially fill orders because forms may be temporarily in short supply. When this occurs, you may receive fewer copies than requested. A notice will be included with your partial order. The balance of your order is retained and filled when the forms become available. You do not need to resubmit the request.

ETF recommends maintaining a small supply of the following publications for reference material, distribution to employees, and to assist you with your administrative duties to the Group Health Insurance program.

Title	Form Number
<i>Your Benefit Handbook</i>	ET-2119
<i>It's Your Choice</i> booklet	ET-2107, ET-2127 – Graduate Assistants
<i>SMP–State Employees and Standard Plan–State Employees</i>	ET-2143, ET-2112
<i>Group Health Insurance Application</i>	ET-2301 (Graduate Assistants, ET-2302)
<i>Continuation - Conversion Notice</i>	ET-2311
<i>Health Insurance Information Change</i>	ET-2329
<i>Insurance Complaint</i>	ET-2405
<i>Death Benefits</i>	ET-6101

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The Wisconsin State Employee Group Health Insurance program consists of three types of plans: Alternate Health Plans, Standard Plan and State Maintenance Plan.

**201 Alternate Health Plans (HMOs)**

Alternate health plans are typically Health Maintenance Organizations (HMO) that provide comprehensive benefits at a lower cost than the Standard Plan in exchange for some health care provider limitations. All alternate health plans participating in the Group Health Insurance program offer the same level of coverage, called Uniform Benefits, with the exception of dental coverage that may be offered at the discretion of the health plan. Uniform Benefits are designed to ease employee health plan selection and assist ETF's efforts to negotiate quality care at the lowest possible cost. With Uniform Benefits, employees can select a health plan based on cost, quality of services, and access to specific physicians or other health care providers.

**202 Standard Plan**

The Standard Plan is a self-insured plan that pools the combined claims experience of its State employees and retirees. The Standard Plan is a fee-for-service indemnity plan. That is, employees enrolled in the Standard Plan can see a provider of their choice and are not restricted to specific providers, as with HMOs. However, the Standard Plan is a Preferred Provider Plan (PPP) meaning that participants are allowed to see the provider of their choice, but with differences in benefit levels depending on whether participants go to an in-network (higher benefit level) or an out-of-network (lesser benefit level) provider.

**203 State Maintenance Plan (SMP)**

The State Maintenance Plan (SMP) is another self-insured plan, but is available only in those counties that do not have a qualified Tier 1 alternate health plan (qualified HMO) as designated in the current *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127). To be qualified, a plan must meet minimum provider availability requirements. SMP offers Uniform Benefits and subscribers must live or work in a Wisconsin SMP county to be eligible to enroll in SMP.

## **204 Three-Tier Health Insurance Program**

Nationally, health insurance costs have been rising at double-digit rates for the last five years, and this trend is expected to continue for several years to come. The State of Wisconsin implemented changes to the Wisconsin State Employee Health Insurance program that are helping the State to avoid this trend of escalating costs. One of those changes is the 3-Tiered approach to health insurance purchasing.

Prior to the passage and signing of the 2003-2005 biennial budget during July of 2003, state statutes required the state to pay health plan premiums of up to 105% of the lowest-cost health plan in a particular county. Any health plan that bid within 5% of the lowest-cost health plan was provided at no cost to employees, just like the health plan that submitted the lowest bid. This 105% formula had some significant shortcomings and did not create incentives for health plans to hold down premium costs. Because health plans are priced by county, employees in different counties often paid different amounts for the same health plan. Finally, the formula drove up the cost of the Standard Plan to the point that this health plan became unaffordable for many state employees.

The 3-Tier model, recommended by the Group Insurance Board and adopted in the 2003-2005 biennial budget, was designed to address these problems while maintaining high-quality, low-cost health care coverage. While still maintaining a uniform medical insurance benefits package, each health plan has now been assigned to one of three tiers based on the relative efficiency with which a health plan is able to provide the benefits and the quality of care required by the Board. Plans were given extra credit in the tier assignment process if they scored well on measures of quality, patient safety, and customer satisfaction. This approach has created significant incentives for health plans to hold down the costs they charge the state while guaranteeing that all state employees have access to a Tier 1 health plan. In addition, monthly premium contributions for the Standard Plan have been capped.

## **205 Pharmacy Benefit Manager (PBM)**

A Pharmacy Benefit Manager (PBM) is a third party administrator of the prescription drug program and is primarily responsible for processing and paying prescription drug claims. All participants in the Group Health Insurance program receive their pharmacy benefits through the PBM regardless of the health plan they have chosen. The PBM allows ETF to uniformly administer pharmacy benefits for all participants.

Subscribers receive separate identification (ID) cards from the PBM and must present that ID card to their pharmacist when filling a prescription. Please contact the PBM for questions pertaining to the pharmacy benefit (e.g. drug formularies, claims, replacement ID cards, etc.) Refer to subchapter 107 for information on contacting the PBM.

## **206 Health Plan Contacts**

Health premiums, benefits, provider networks and program policies and procedures may change annually. Such changes are communicated to employers through *Employer*

*Bulletins* and to employees through the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127) as well as through communications from the health plans (e.g., provider listings). Contact the health plan representative directly with specific questions regarding such topics as referral policies, benefits, filing of claims, and/or provider networks. Health plan addresses and phone numbers are listed in the *It's Your Choice* booklet. A listing of *Health Plan Contacts* (ET-1728) is available online at ETF's Web site (<http://etf.wi.gov>) under the "Employer" section.

## **207 Coordination of Benefits (COB)**

For a variety of reasons, some individuals are covered under more than one group health insurance plan. When this occurs, the benefits are paid, or "coordinated," according to insurance regulations used to determine the order in which the plans will pay benefits. The plan that pays first is called the "primary plan" and the plan that pays next is the "secondary plan." The insurance regulations for determining the order in which plans will pay benefits are described in the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127). Questions about COB can also be directed to health plans.

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**301 Coverage Eligibility**

For group health insurance purposes (per Wis. Stats. § 40.02 (25)(b)), eligible employees include:

- Any State employee covered under the Wisconsin Retirement System (WRS).
- Any teacher employed by the University of Wisconsin for an expected duration of not less than six months with at least a one-third full-time appointment.
- Any person employed as a graduate assistant and other employees-in-training designated by the Board of Regents of the University of Wisconsin System, who are employed on at least one-third full-time basis.
- The surviving spouse and dependents of an active or retired State employee who was a participant in the Group Health Insurance program at the time of their death.
- Any insured employee who is retired on an immediate or disability annuity, or who receives a lump sum payment under WRS which would have been an immediate annuity if paid as an annuity.
- Any participating State employee who terminates after attaining 20 years of

creditable service and remains a participant in WRS (that is, does not take a separation benefit, or who is eligible for an immediate annuity but defers application).

- Any employee on layoff whose health insurance premiums are being paid from accumulated unused sick leave (Wis. Stats. § 40.05 (4)(bm)).
- Any other State employee for whom coverage is authorized under a collective bargaining agreement.
- Any blind employee of WISCRAFT authorized under Wis. Stats. § 47.03 (1)(b) or § 47.03 (1m), who has completed 1,000 hours of service.
- Any rehired annuitant electing to return to active WRS participation is immediately eligible to apply for health insurance coverage through the active employer (any State Agency or local employer that participates in the Wisconsin Public Employers Group Health Insurance program).

### **302 State Premium Contribution Eligibility**

To be eligible to receive the State contribution toward the premium payment (the State share), the employee must meet one of the following requirements:

- Be a covered employee under the WRS, having been employed by the State of Wisconsin (local government service does not apply) for a minimum of six months. (See subchapter 303 to determine prior service.) A leave of absence may extend the effective date of the State share payment.
- Be a new employee with at least six months prior service as a State or University of Wisconsin employee. (Except University Faculty; see below.)
  - a. The new employee must submit an application for health coverage within 30 calendar days of the first day of employment.
  - b. In the event the application is submitted beyond the 30-day period, the new employee is restricted to the Standard Plan with a waiting period for pre-existing conditions.
- Be a graduate assistant or employee-in-training at the University of Wisconsin.
- Be a teacher who is a participating employee and who is employed by the University of Wisconsin for an expected duration of not less than 6 months with at least a one-third full time appointment (UW Faculty). UW Faculty members are eligible for the State premium contribution beginning on the date coverage begins.
- Be a member of the Legislature or elected State official, an employee of the Legislature, a state constitutional officer, a Justice of the Supreme Court, a Court of Appeals judge, a Circuit Court judge, the chief clerk or sergeant at arms of the Senate or Assembly, or a district attorney who did not elect under § 978.12 (6) to continue insurance coverage with a county (or who did elect such coverage but

terminated that election and elected State covered within 3 months of the terminated election). These employees are eligible for the State premium contribution beginning on the date coverage begins.

- Be a blind employee of Workshop for the Blind (WISCRAFT) with at least 1,000 hours of service.

A. Premium Share for Full and Part-time Employees

Prior to the passage and signing of the 2003-2005 biennial budget during July of 2003, state statutes required the State to pay health plan premiums of up to 105% of the lowest-cost health plan in a particular county. The 2003-2005 biennial budget enacted the 3-Tier model with employee premium shares based on the three separate tiers. (The 3-Tier model is explained in Chapter 2.) Wis. Stats. § 40.05 (4)(ag, ar) provide guidance regarding the state premium contribution. Compensation plans and bargaining agreements, approved by the State legislature, determine the exact employee and employer share during each biennium. The employer share for part-time eligible employees is also subject to compensation plans.

**Note: As stated in Wis. Stats § 40.05 (4)(ag), the State premium share for employees working fewer than 1,566 hours per year is limited to half the State premium share provided for employees working 1,566 or more hours per year. However, the current (in effect at publication) compensation plans and bargaining agreements provide full State premium shares for employees with appointments of 1,044 hours or more.**

B. Premium Share for Limited Term Employees (LTEs)

Once LTEs begin participation under the WRS, they are immediately eligible to enroll in the Health Insurance program by paying the entire premium, or they may defer enrollment until the State contributes toward premium on the first day of the seventh month after WRS participation begins.

LTEs appointed to work fewer than 1,044 hours per year pay half the total premium cost with the State paying the remaining half. Employees hired to work concurrent WRS eligible LTE appointments totaling more 1,044 hours or more per year, either with the same state agency or different state agency, are treated as full-time employees for the determination of the employer share.

**Note:** LTEs who decline to enroll in the Wisconsin State Employee Group Health Insurance program when they first begin participation in WRS will not receive a second opportunity to enroll in health insurance without restrictions when appointed to a permanent position, unless there has been a 30-day break in employment between the LTE and the permanent position. Employees without the 30-day break in employment are only eligible to enroll in the Standard Plan with a 180-day waiting period for pre-existing medical conditions.

C. Premium Share for Graduate Assistants

Under Wis. Stats. § 40.52 (3), separate health insurance coverage is made available to University of Wisconsin Graduate Assistants, employees in training, short term academic staff, fellows and scholars. Refer to the *It's Your Choice* booklet (ET-2127) for eligibility and enrollment requirements.

The University of Wisconsin contribution is the total premium less the above employee share.

**D. Premium Share for Other Represented and Non-Represented Employees**

Some represented employees may have different State share contributions. Consult the applicable collective bargaining contracts. Some non-represented employees may also have different State share contributions. Consult applicable Office of State Employment Relations publications.

**E. Premium Share for Covered Employees on Military Leave**

The State premium share for employees on military leave continues beyond the three months normally allowed under leave of absence provisions. Employees on military leave who have not yet fulfilled the six month employment provision are eligible for the State premium share on the date they would have been eligible had the military leave not occurred.

### **303 Determining Effective Dates of State Premium Contribution**

For employees without a break in service during the first six months of employment **and** no previous WRS service as a State or University of Wisconsin employee, whose employment begins:

- On the first of a month - Add six months to determine the month in which the employee is eligible to receive the State share contribution.
- On the 2nd through the 31st of a month - Add seven months.

EXAMPLE: Hire date of March 2; health insurance application received September 30.

Solution: The employee is eligible for participation in the health insurance program with State share effective October 1. The health insurance application must be received on or before October 1.

These dates are determined by adding seven to the hire date because the employee was hired between the second and thirty-first of the month without a break in service and no previous WRS service.

Whenever an employee has a break in service and no previous State WRS service, any period worked in a month is counted as a month towards WRS service.

EXAMPLE: Hire date of August 26; employee terminates or goes on a LOA

beginning on December 5; employee returns to work on January 15; no prior service before August 26.

**Solution:** Because there is a break in service, any period worked in a month means that month is counted as a full month towards WRS service. So, the months of August, September, October, November, December and January are counted as there were hours worked in each, totaling the needed six months. The employee is eligible for State share February 1 if a health insurance application was received on or before that date.

NOTE: In this instance, the employee has until February 14 to submit a completed health insurance application (30 days from the date of return to work) for a plan of their choice without a waiting period for pre-existing conditions. For an application received on or before February 1, coverage is effective February 1. The coverage effective date is March 1 for an application received between February 2 and February 14.

Employees with six months WRS prior service as a State or University of Wisconsin employee are eligible to apply within 30 calendar days of hire with coverage effective the first of the month following the employer's receipt of the application and are immediately eligible for the appropriate State premium share.

### 304 WRS Previous Service Check

A WRS previous service check must be performed for each employee applying for health insurance to determine the appropriate State contribution share and effective date of State contribution.

ETF provides three methods for employers to use in determining whether an employee has previous State and/or University of Wisconsin service:

- Access to the Previous Service Benefit Inquiry Screen on ETF's Extranet site at <http://etfextranet.it.state.wi.us/>.

**Note: This is a password-protected site. To obtain access, refer to Chapter 24 of the *Wisconsin Retirement System Administration Manual*.**

- Complete a *WRS Previous Service Checks* form (ET-1715) found in subchapter 305 and fax it to ETF at (608) 266-5801.
- Call the Employer Communication Center at (608) 264-7900 or toll-free at (888) 681-3952 and request a previous service check.

305 WRS Previous Service Checks Form (ET-1715)

Department of Employee Trust Funds  
 Division of Trust Finance & Employer Services  
 PO Box 7931 - Madison WI 53707-7931  
 Fax: (608) 266-5801

**WRS PREVIOUS SERVICE CHECKS**

To verify previous Wisconsin Retirement System (WRS) service, complete the following information: your name/agency, phone number, fax, EIN, re: employee's name, Social Security Number, birthdate and date sent. Do not write in the ETF Review area, additional comments or completion date.

From: Name/Agency	Phone Number:	Fax:	EIN: 69-036-
Employee:	SSN:	Birthdate:	Date Sent:
<b>ETF Review</b>			
<input type="checkbox"/> No previous service. <input type="checkbox"/> Qualifying state service. ____ months. <input type="checkbox"/> Qualifying local service. ____ months. <input type="checkbox"/> Took a separation benefit on _____. <input type="checkbox"/> Is an annuitant: <input type="checkbox"/> WRS Termination date is _____. <input type="checkbox"/> Retirement Annuity application received by ETF on _____. <input type="checkbox"/> Retirement Annuity effective date is _____.			
Additional Comments:			Completion Date:

Employee:	SSN:	Birthdate:	Date Sent:
<b>ETF Review</b>			
<input type="checkbox"/> No previous service. <input type="checkbox"/> Qualifying state service. ____ months. <input type="checkbox"/> Qualifying local service. ____ months. <input type="checkbox"/> Took a separation benefit on _____. <input type="checkbox"/> Is an annuitant: <input type="checkbox"/> WRS Termination date is _____. <input type="checkbox"/> Retirement Annuity application received by ETF on _____. <input type="checkbox"/> Retirement Annuity effective date is _____.			
Additional Comments:			Completion Date:

Employee:	SSN:	Birthdate:	Date Sent:
<b>ETF Review</b>			
<input type="checkbox"/> No previous service. <input type="checkbox"/> Qualifying state service. ____ months. <input type="checkbox"/> Qualifying local service. ____ months. <input type="checkbox"/> Took a separation benefit on _____. <input type="checkbox"/> Is an annuitant: <input type="checkbox"/> WRS Termination date is _____. <input type="checkbox"/> Retirement Annuity application received by ETF on _____. <input type="checkbox"/> Retirement Annuity effective date is _____.			
Additional Comments:			Completion Date:

### 306 Initial Enrollment and Effective Dates

Employers should immediately upon hire provide newly eligible employees with the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127) and the *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302). All eligible employees must submit a completed application, even those who do not wish to enroll (Refer to subchapter 307).

Employees can avoid limitations of plan selection and the pre-existing conditions waiting period by enrolling:

- Within 30 days of their date of hire. Coverage is effective the first day of the month that occurs on or after the date the application is received by the State agency.

or

- Prior to the date the employee becomes eligible for the State contribution toward premium. Coverage is effective the first day of the month on or following the date the employee becomes eligible for the employer contribution.

**NOTE: Employees failing to enroll during a specified enrollment period are limited to the Standard Plan and subject to a 180-day waiting period for all pre-existing conditions. (Refer to subchapter 308 for other enrollment opportunities.)**

Employees may elect to enroll in the Group Health Insurance program before the State contribution towards health insurance premiums begins. These employees have the option to change health plans and/or coverage levels effective on the first of the month that the State contribution begins. Employees canceling coverage prior to the date that the State contribution begins may re-enroll with the coverage becoming effective on the first of the month that the employer contribution begins.

When both spouses are employed by the State and/or the University of Wisconsin (or one is an annuitant) both may retain or select single coverage with their current plan or one may retain or select family coverage under one of their current plans that will cover the other spouse and any eligible dependents. However, family coverage and single coverage cannot be held simultaneously.

If the husband and wife are each enrolled for single coverage, one of the single contracts may be changed to a family contract at any time without restriction and the other single contract cancelled. Family coverage is effective on the first of the month following receipt by the employer of a *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302).

Similarly, one family policy may be split into two single plans with the same health plan effective the first of the month following receipt by the employer of a *Group Health Insurance Application* (ET-2301 or ET-2302) from both spouses. However, in the event a husband and wife each have single coverage, no dependents are covered and should one spouse die, that individual's sick leave credits will not be available for use by the

surviving spouse.

### 307 Declining Coverage

An employee declining to enroll in the Group Health Insurance program when initially eligible must complete (mark the appropriate box waiving coverage, sign, and date) a *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) indicating that coverage is being declined. Employees should be reminded that once coverage is declined, coverage elected at a later date is limited to the Standard Plan with a 180-day waiting period for ALL pre-existing conditions. The only exception is the onset of qualifying events creating special enrollment opportunities as described in subchapter 308.

### 308 Enrollment Opportunities for Employees who Previously Declined/Cancelled Coverage

Employees electing not to enroll during a designated enrollment period can elect coverage at any time in the future, but that enrollment is limited to the Standard Plan with a 180-day waiting period for ALL pre-existing conditions. The effective date of coverage is the first of the month following the employer's receipt of a *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302). The employee may participate in the next Dual-Choice enrollment period following the effective date of coverage.

Under Federal law and by contract, the following events create an opportunity for employees who previously declined or cancelled coverage to enroll in any health plan without the limitation of a 180-day waiting period for pre-existing conditions:

- A. Loss of Other Coverage: Employees who declined coverage under the Group Health Insurance program due to the following circumstances:
- Coverage under another health insurance plan;
  - Coverage under medical assistance (Medicaid);
  - Coverage as a member of the US Armed Forces;
  - Coverage as a citizen of a country with national health care coverage comparable to the Standard Plan options.

and who lose eligibility for the other coverage (does not include voluntary cancellation of the other coverage) or the employer's premium contribution for the other coverage ceases, may take advantage of a special 30-day enrollment period (beginning on the date the other health insurance coverage terminates) without waiting periods for pre-existing conditions. A *Group Health Insurance Application* (ET-2301 or ET-2302) and other information documenting the loss of coverage or employer premium contribution must be received by the employer within 30 days of the date the other coverage or the employer premium contribution ended. Copies of all documentation must be submitted with the ETF advance copy of the *Group Health Insurance Application* (ET-2301 or ET-2302). Coverage is effective on the day

following the last day of the other coverage.

**NOTE: The special enrollment period is not available if the employee and/or their dependents remain eligible for coverage under a health insurance plan that replaces the other plan without an interruption of coverage.**

- B. Change in Coverage Level: Employees enrolled in single coverage, though eligible for family coverage, may change to family coverage if any eligible dependents covered under another health insurance plan lose eligibility for that coverage or the employer's contribution towards the other coverage ceases.

The special 30-day enrollment period begins on the date the other health insurance coverage terminates. Employees must submit a *Group Health Insurance Application* (ET-2301 or ET-2302) to their employer during the special 30-day enrollment period along with documentation of the loss of other coverage, or the employer contribution ending. Copies of all documentation must be submitted with the ETF advance copy of the *Group Health Insurance Application*. Coverage is effective on the day following the last day of the other coverage or the day following the date on which the employer premium contribution ends.

**NOTE: The special enrollment period is not available if the employee and/or their dependents remain eligible for coverage under a health insurance plan that replaces the other plan without an interruption of coverage.**

- C. Birth/Adoption/Marriage: Employees who declined coverage under the Group Health Insurance program have a special opportunity to enroll in family coverage if they have a new dependent as a result of marriage, birth, adoption, or placement for adoption. Coverage is effective on the date of marriage if an application is submitted within 30 days of that date. Coverage is effective on the date of birth, adoption, or placement for adoption if an application is submitted within 60 days of the birth, adoption, or placement for adoption.
- D. Increase in Hours for LTEs and less than half-time employees: LTEs and less than half-time employees who initially decline health insurance coverage and whose hours increase to half-time or more, have a new enrollment opportunity. These employees may enroll in any plan without restriction and have 30 days from the date of the employer contribution increase to file a *Group Health Insurance Application* with the employer. Coverage is effective the first of the month following the employer's receipt of the application.

Example: An employee in a WRS-covered position appointed to work fewer than 1,044 hours is eligible for less than half-time employer premium contributions and elects not to participate in health insurance coverage. The employee later receives an appointment, effective October 1, 2006, for 1,044 hours or 50% time. (See Note regarding number of hours in Subchapter 302 [A]). The employee now has an additional enrollment opportunity due to this increase in hours. The employee can file an application on October 1 for coverage effective October 1, or the employee can file the application with the employer on or before October 30, 2006 (30 days from being hired into the new appointment) for coverage effective November 1, 2006.

Employees who fail to enroll during this additional enrollment opportunity will only be eligible to elect insurance coverage under the Standard Plan with a six-month (180--day) waiting period for pre-existing conditions.

**A full month's premium is due for the month if coverage or change in coverage level is effective before the 16<sup>th</sup> of the month. Otherwise, the new premium rate goes into effect the following month.**

### 309 **Completing the *Group Health Insurance Application* (ET-2301; Graduate Assistant, ET-2302)**

Verify the employee's eligibility for group health insurance coverage (Refer to subchapter 301). Provide the employee with the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127) and *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302). Inform the employee of the deadline for submitting the application to ensure the selection of any health plan without limitation and to receive the identification cards prior to the coverage effective date.

Each eligible employee must submit the application to the employer even if declining coverage. It is important there is written documentation indicating the employee declined coverage. The employee should complete the application, following the instructions on the application cover sheet. The employer must verify that the information is complete, accurate and legible. Complete the employer information section as described below, indicating the date the application was received.

In the employer section at the bottom of the application, the employer must enter:  
**(Refer to Chapter 11 for applicable codes.)**

- a. Employer Number (EIN) - 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**). (Graduate Assistant application [ET-2302] is hard-coded 69-036-0001-131.)
- b. Name of Employer (Graduate Assistant application is hard-coded UW.)
- c. Program Option Code – LOCAL GOVERNMENT EMPLOYERS ONLY (Graduate Assistant application [ET-2302] is hard-coded P01.)
- d. Surcharge Code – LOCAL GOVERNMENT EMPLOYERS ONLY (Graduate Assistant application [ET-2302] is hard-coded S01.)
- e. Five-digit Group # - The five digit number assigned to State agencies (e.g., **84535**). (Graduate Assistant application [ET-2302] is hard-coded 83445.)
- f. Enrollment Type code - Identifies the reason for submitting an application. (Refer to Subchapter 1104.)
- g. Employee Type - Enter the appropriate code. (Refer to Subchapter 1103.)
- h. Coverage Type Code - Coverage code identifying single or family coverage. (Refer to Subchapter 1102.)
- i. 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.)
- j. Standard Plan Waiting Period – Code ("01" Dependents [Spouse and Children only] or "02" All Family Members [Employee and Dependents]) identifies the person(s) for

- whom the waiting period applies.
- k. Participant County Code – Code identifying the county of the subscriber's place of residence. (Refer to subchapter 1101.)
  - l. Physician County Code – Code identifying the county in which the subscriber's selected physician or clinic is located. This field does not appear on the ET-2302 for Graduate Assistants. (Refer to subchapter 1101.)
  - m. Previous Service - Complete Information - Check the appropriate response for each question. (This field does not appear on the ET-2302 for Graduate Assistants.)
  - n. Date Application Received by Employer - The date the employer received the completed application. It is important this date be accurate in order to determine if the application was received on a timely basis.
  - o. Date Employment Began - The month, day and year the employee began WRS employment with the employer. For rehired employees, enter the rehire date.
  - p. Monthly Employee Share - The amount the employee contributes toward the monthly premium for the health plan selected. (Refer to subchapter 302.)
  - q. Monthly Employer Share - The amount the employer contributes toward the monthly premium for the health plan selected. (Refer to subchapter 302.)
  - r. Event Date - ONLY complete this field indicating the date of the event IF the reason for submitting an application is one of the following:
    - marriage
    - return from a leave of absence or layoff and coverage had lapsed
    - change from a single to family contract due to the addition of an eligible dependent
    - change from family to single coverage due to the deletion of last eligible dependent
    - divorce which resulted in a change of coverage from family to singleOtherwise, leave this field blank.
  - s. Prospective Date of Coverage - The month, day and year the coverage should be effective. (Refer to subchapters 303 and 306.)
  - t. Payroll Representative Signature - Acknowledging the date the employer received the application and that an audit of the application has been completed.
  - u. Telephone number - of the employer representative who signed the application.

Distribute the application copies as follows:

1. ETF Advance Copy - send immediately to ETF with copies of any required documentation. Refer to subchapter 108 for the mailing address.
2. Carrier Advance Copy - send immediately to the corresponding health plan.
3. Employer Copy - retain for your records.
4. ETF Coverage Report Copy - Submit to ETF with the appropriate month's *Monthly Additions Report* (ET-2610). (Refer to subchapter 502).
5. Employee Copy - return to the employee.

310 Group Health Insurance Application (ET-2301)

ETF Use Only		State of Wisconsin Department of Employee Trust Funds <b>HEALTH INSURANCE APPLICATION</b>				Employer Notes					
Applicant's Social Security Number			Spouse's/Ex-Spouse's/Dependent of/Survivor of: Name & Social Security Number								
Applicant—Last Name		First	Middle	Maiden Name	NEW HEALTH PLAN SELECTED						
Address—Street and No.			City	State	CURRENT HEALTH PLAN						
Postal Code	County		Country (if not USA)								
ELIGIBILITY STATUS (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant <input type="checkbox"/> Other				I WANT MY COVERAGE TO BE EFFECTIVE: <input type="checkbox"/> As soon as possible <input type="checkbox"/> When employer contributes premium							
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Widowed (date) _____ <input type="checkbox"/> Divorced (date) _____ <input type="checkbox"/> Married (date) _____											
A. REASON FOR SUBMITTING APPLICATION											
<input type="checkbox"/> Initial Enrollment – 02		<input type="checkbox"/> Dual-Choice - 40		<input type="checkbox"/> LTE/half-time employee elig. for new enrollment period – 02							
<input type="checkbox"/> Cancellation – 09		<input type="checkbox"/> Moved from Service Area – 41 Date: _____		<input type="checkbox"/> Transfer from One State Agency to Another - 04							
<input type="checkbox"/> Change to Family Coverage – 43		<input type="checkbox"/> Spouse to Spouse Transfer – 31		<input type="checkbox"/> COBRA (or continuation) – 63							
<input type="checkbox"/> Change to Single Coverage – 44 or 45*		Name of State Agency: _____		<input type="checkbox"/> Other: _____							
* The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) up to 36 months. See your Payroll Representative for information.											
B. COVERAGE DESIRED <input type="checkbox"/> Single (Applicant Only) <input type="checkbox"/> Family (Applicant, Eligible Spouse, Eligible Children)											
Last Name		First	Middle	Maiden	Birthdate	Gender	Social Security	Rel. Code	Student Status	SELECTED PHYSICIAN OR CLINIC. Indicate "NONE" if electing Standard Plan.	
					MO   DAY   YR	M/F	Number				Name (Last, First)   County
Applicant											
Spouse											
Dependent Children											
Children include: your natural children who are dependent upon you or the other parent for at least 50% of their support and are your natural children, legal wards who became your ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.											
C. OTHER COVERAGE — If you or any family member listed above is covered under other group health insurance, including MEDICARE, list.											
Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes - Covered under Medicare name(s): _____											
HIC# _____   Eff. Date: _____											
Other Coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes Through the State of WI, including University of WI? <input type="checkbox"/> No <input type="checkbox"/> Yes   Insurance Company _____											
Name(s) of Insured(s) _____											
Group No. _____   Subscriber (Policy) No. _____   Name of Employer _____											
<input type="checkbox"/> I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the <b>TERMS AND CONDITIONS on the reverse side.</b> A copy of this application is to be considered as valid as the original.											
<input type="checkbox"/> I do not wish to enroll at this time, or I wish to cancel my current coverage.											
SIGN HERE & Return to Employer		Applicant Signature				Date Signed (MM/DD/CCYY)		Home Telephone Number ( )			
								Daytime Telephone ( )			
EMPLOYER COMPLETES AREA BELOW   Coding Instructions are in the Employer Health Insurance Manual											
Employer Number 69-036-		Name of Employer				Program Option Code		Surcharge Code			
Group Number	Enrollment Type	Employee Type	Coverage Type Code	Carrier Suffix	Standard Plan Waiting Period	Participant County Code	Physician County Code				
Previous Service – Complete Information					Date Application Received by Employer (MM/DD/CCYY)		Date Employment Began (MM/DD/CCYY)				
1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No											
2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No											
3. Source of previous service check: <input type="checkbox"/> Extranet <input type="checkbox"/> ETF											
Monthly Employee Share		Monthly Employer Share			Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)				
\$		\$									
Payroll Representative Signature						Telephone ( )					

### 311 Identification (ID) Cards

Subscribers will receive an ID card from the health plan for use when obtaining medical services and a separate ID card from the Pharmacy Benefit Manager (PBM) to be used when filling prescriptions. (Refer to subchapter 205 for further information about the PBM.) Member identification numbers are different on each card. Submit application forms at least one month prior to the effective date whenever possible to allow sufficient time for the health plan and PBM to issue the ID cards to the subscriber prior to the effective date.

Subscribers can contact the health plan and PBM directly to request additional ID cards. Phone numbers for the health plans and PBM are listed in the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127).

### 312 Coverage During Leave of Absence (Non-military)

Insured employees on a leave of absence (LOA) choose whether to continue health insurance coverage during the leave. A LOA is any period in which an employee is not working for, or receiving earnings from, the employer **and** has not terminated the employer-employee relationship as defined in Wis. Stat. §40.02(40). An employee on LOA is subject to the same eligibility and enrollment provisions as an active employee. A LOA is considered terminated when an employee returns to work for 30 consecutive calendar days for an accumulation of hours of at least 50% of their normal work time.

#### A. Employee on LOA Continues Coverage:

The following apply to employees continuing health insurance coverage during an approved LOA:

- The maximum length of time coverage can be continued for an employee on LOA is **36 months**. After 36 months or upon termination (whichever occurs first), coverage may be continued under continuation coverage regulations. (Refer to Chapter 7 for information about continuation coverage.)
- Premiums must be paid in advance, either by deduction from the last payroll check or by direct payment to the employer. Employers must receive premium payments in advance of the coverage month.
- The State share contribution toward premium payment continues for the first three months of the LOA for which premiums have not already been deducted as of the date the LOA begins. This will result in a total of up to five months (after the LOA begins) of employer-shared premiums. For the remaining months of the LOA, the employee must pay the entire premium; there is no State contribution after the first three months.
- Employees on LOA are reported along with active employees on the employer's monthly reports to ETF. Any payments received from employees on LOA should

be made payable to the employer and included in the employer's monthly remittance to ETF.

- Employers must provide Dual-Choice information to employees on LOA prior to the beginning of the designated Dual-Choice Enrollment period.
- An employee on a union-service leave may continue coverage beyond 36 months until termination of the leave or the date that service with the labor organization ceases, whichever occurs first.
- Employees continuing coverage while on LOA are not required to complete a *Group Health Insurance Application* (ET-2301 or ET-2302) upon return to work.

B. Employee on LOA Allows Coverage to Lapse - The following apply to employees on approved LOA who allow health insurance coverage to lapse and choose to reinstate coverage upon return to work:

- The employee must submit a *Group Health Insurance Application* and is limited to the same health plan and level of coverage as before the LOA. The application must be received within 30 days of the employee's return to work. Coverage is effective the first of the month following the employer's receipt of the completed *Group Health Insurance Application*. After 30 days, enrollment is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

**Note:** The employee may change level of coverage if a special enrollment opportunity (e.g., marriage, birth, etc.) occurred during the LOA. (Refer to subchapter 305 for information about other enrollment opportunities.) Employees may change health plans if the change results from a move to a different county during the LOA.

- An employee who returns from a LOA that encompassed the entire previous Dual-Choice enrollment period will be allowed a Dual-Choice enrollment opportunity provided an application is filed with the employer within 30 days of the employee's return to work.
- The coverage effective date for employees returning from military leave or Family Medical Leave of Absence (FMLA) is the date the employee returns to work provided an application is filed with the employer within 30 days of the employee's return to work. A full month's premium is due for that month if coverage is effective before the 16th of that month. Otherwise, the entire premium for that month is waived.

The following are examples of situations of FMLA that may be encountered:

- FMLA spans the end of one calendar year and continues into the next year (twelve weeks of one year ending December 31st and twelve weeks beginning January 1st of the next year) - The effective date is the date the employee returns to work, as long as it is not beyond the allowable twelve weeks for the current calendar year.

NOTE: FMLA is based on a calendar year and cannot exceed a twelve-week period in any given calendar year.

- An employee on FMLA exceeds the twelve-week calendar year limit and elects to continue the leave using leave without pay - The effective date of the employee's reinstatement in the Health Insurance Program is the first of the month following the employer's receipt of the employee's health insurance application after completing 30 consecutive calendar days for an accumulation of hours of at least 50% of their appointed employment.

### 313 Coverage During Military Leave of Absence

Wisconsin Act 162 (enacted March 17, 2004) provides a framework for insuring that certain employees serving in the uniformed services are treated, for purposes of pay and benefits, as though no interruption of service occurred. Under this act, employees may continue health insurance coverage while on military leave, if they so desire, **including employer paid premiums and employee paid premium payroll deductions.**

(Employees not remaining on payroll while on military leave must make employee-paid premium share contributions directly to the employer.) Wisconsin Statute 230.315, created by Act 162, lists three criteria to be met by a state employee activated to serve on military duty in order to receive pay differential, accrue sick leave and paid annual leave, and receive other employee benefits as though no interruption of service occurred:

1. Be activated to serve on military duty or in the U.S. Public Health Service, other than for training purposes, on or after January, 1, 2003; and
2. Serve as a member of the Wis. National Guard, a reserve component of U. S. armed forces, or recalled to active military duty from inactive reserve status; and
3. Receive a military leave of absence under s. 230.32 (3) (a) or 230.35 (3), under a collective bargaining agreement, under rules promulgated by the Office of Employment Relations, or is eligible for reemployment under the provisions of s. 45.50.

Employees who prefer to rely solely on military provided health care and family health insurance, may elect to cancel state coverage. Upon release from active duty, return to employment *and* within 30 days of the loss of the military coverage—loss of coverage is defined as an “event”—the employee may reinstate their state health insurance coverage (same health plan and same coverage level) without prejudice by filing a Group Health Insurance Application. The coverage effective date is the day following the last day of the military coverage.

Employees who are not eligible for the employer premium share when called to active duty, but who become eligible while on military leave, have 30 days from the date of their return to employment to file a health insurance application.

### 314 Coverage During Layoff

Coverage may be continued during layoff with the following conditions (Also see Subchapters 803, 804):

- The State contribution is available for the first three months of layoff for which premiums have not already been deducted. After that the employee is responsible for the entire premium.
- Employee may continue coverage for up to five years using converted sick leave to pay premiums until the sick leave credits are exhausted followed by 36 months under continuation provisions. In the event that sick leave conversion credits are used, the full amount of the required employee premiums is deducted from the credits until the credits are exhausted, the employee is re-employed, or five years elapse from the date of the layoff. The use of sick leave during layoff is the record-keeping responsibility of the employer. The employee is reported to ETF the same as any other employee on layoff who is continuing their coverage. (For more information on sick leave, see Chapter 8 - Accumulated Sick Leave Conversion Credits.)
- Premiums must be paid in advance, either by deduction from the last paycheck or by direct payment to the employer. Payments must be received by the employer prior to the period of coverage.
- Employees on layoff are reported along with your active employees and employees on LOA. Any payments received from employees on layoff should be made payable to the employer and included in your monthly remittance to ETF.
- If an employee is on layoff during an entire Dual-Choice Enrollment period, the employee must be given a Dual-Choice opportunity. Dual-Choice information should be sent to those employees who are on layoff prior to the beginning of the designated Dual-Choice Enrollment period.

The following apply to employees on layoff status who allow health insurance coverage to lapse and choose to reinstate coverage upon return to work:

- The employee must submit a *Group Health Insurance Application* (ET-2301 or ET-2302) and is limited to the same health plan and level of coverage as before the layoff. The application must be received within 30 days of the employee's return to work. Coverage is effective the first of the month following the employer's receipt of the completed *Group Health Insurance Application*. After 30 days, enrollment is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.
- The employee may change level of coverage only if a special enrollment opportunity (e.g., marriage, birth, etc.) occurs during the layoff. (Refer to subchapter 305 for information about special enrollment opportunities.)
- Employees moving to a different county during a layoff may change health plans.
- An employee who returns from a layoff that encompassed the entire previous Dual-

Choice enrollment period will be allowed a Dual-Choice enrollment opportunity provided an application is filed with the employer within 30 days of the employee's return to work.

### **315 Coverage During Appeal of Discharge**

An insured employee appealing an employment discharge may continue to be insured from the date of the contested discharge until a final decision is made. The following apply:

- The employer must receive the first premium payment within 30 days of discharge.
- Future premium payments must be made through the employer agency and must be received in advance of the coverage month.
- The employee must pay both the employee and state share of premium due each month until the appeal is resolved.

In the event the appeal is decided in favor of the employee and the employee is made whole (as if the discharge did not occur), the employer must reimburse the employee for all State premium shares paid by the employee during the course of the appeal process. The employer is not required to return the State share in cases where the employee is not made whole but returns to work under the terms of the final agreement.

In the event an appeal reinstates an employee who allowed coverage to lapse during the appeal, the employee may reinstate coverage provided the employee re-applies for coverage within 30 days of the return to work.

If the final decision is adverse to the employee, the date of termination shall, for purposes of health care coverage, be the end of the month in which the decision becomes final.

If the discharge is for reasons other than gross misconduct, the employee is eligible to continue health insurance for the balance of 36 months from the original termination date (the balance of the continuation period). If the discharge is for gross misconduct, the employee is eligible for conversion coverage and should contact the health plan for information on benefits, rates and policy provisions. (Refer to Chapter 6 for information about continuation and conversion.) A *Continuation - Conversion Notice* (ET-2311) must be provided to the employee using the original discharge date.

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	1. <i>Group Health Insurance Application</i> (ET-2301; Graduate Assistants, ET-2302) (if changing from single to family coverage).; or 2. <i>Health Insurance Information Change</i> (ET-2329) form (if no change in coverage) 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.	<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>

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 5 — MONTHLY REPORTING**

Users of the automated system for monthly reporting should also refer to Chapter 12 – “Automated Monthly Reporting” instructions.

- 501 Overview of Monthly Reports**
- 502 Completing the *Monthly Additions Report* (ET-2610)**
- 503 Completing the *Monthly Deletions Report* (ET-2612)**
- 504 Completing the *Monthly Changes Report* (ET-2614)**
- 505 Completing the *Monthly Coverage Report* (ET-1607)**
- 506 Completing the *Health Insurance Summary* (ET-1608)**
- 507 Assembly of Health Insurance Reports**
- 508 Premium Remittance**
- 509 Credits**

**501 Overview of Monthly Reports**

Each month, employers must report the total number of contracts (by health plan) for their employees and remit the corresponding premium payments to ETF. It is extremely important that the monthly reporting forms are completed accurately to ensure the premium remittance is correct.

To minimize errors, all data on the monthly reports must be either typewritten or legibly printed.

**NOTE: Health plans and the Pharmacy Benefit Manager update eligibility records based on monthly additions, deletions, and change reports. Consequently, these reports must be accurate and complete. For example, an incorrect effective date can lead to difficulties in filling prescriptions.**

Monthly reports for active employees consist of the following, listed in the order they would generally be completed:

- A. *Monthly Additions Report* (ET-2610) - Used to report new contracts for each health plan. (Refer to Subchapter 502.)
- B. *Monthly Deletions Report* (ET-2612) - Used to report contracts terminating from each health plan. (Refer to Subchapter 503.)
- C. *Monthly Changes Report* (ET-2614) - Used to report changes in coverage—single to family and family to single—within each health plan. (Refer to Subchapter 504.)
- D. *Monthly Coverage Report* (ET-1607) - Used to summarize the net change in coverage for each reporting month based on the monthly additions, monthly deletions, and monthly changes reports for each health plan in which employees are enrolled. The contract numbers from line 6 (Contracts in Effect This Month) on the

previous *Monthly Coverage Report* must be used on line 1 (Contracts in Effect Last Month) on the current *Monthly Coverage Report*.

- E. *Health Insurance Summary* (ET-1608) - Used to summarize the results of the *Monthly Coverage Reports* for that coverage month. (This summary is the employer and employee share of the premiums for each health plan in terms of dollars; contract numbers (quantities) do not appear on this report.)

Each report is discussed in detail within the remaining sections of this chapter.

## 502 **Completing the *Monthly Additions Report* (ET-2610)**

The *Monthly Additions Report* is used to report any new contracts that have been added during the month. A separate report must be filed for each health plan, every coverage month for which there are contracts added. A completed application must also be attached to the report for each added contract.

To complete the *Monthly Additions Report*, enter the following information:

- A. Employer Name.
- B. Employer Number - The employer identification number (EIN) is the number assigned to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**0001-114**).
- C. Five-digit Group # - The five digit number assigned to State agencies (e.g., **84535**).
- D. 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* (ET-1607) for the plan suffix codes.)
- E. Deduction Month - Optional - Employer may use for internal purposes.
- F. Coverage Month - The month and year for which coverage is being reported.
- G. List employee last names—in alphabetical or social security number order—for each contract being added. Enter the following information as it appears on the completed and attached *Group Health Insurance Application* (ET-2301):
- Enrollment Type/Code - This code identifies the reason for submitting an application. (“Enrollment Type Code” field on the application.)
  - Employee Type/Code - Enter the appropriate code. (Refer to Subchapter 1103.)
  - Name Last, First, Middle I. - Employee name in alphabetical order by last name or in numeric order by social security number.
  - Social Security No - List the employee’s social security number.

- Date of Hire or Re-hire - The month, day and year the employee began employment with the employer. For rehired employees, enter the rehire date. (From the “Date Employment Began field on the application.)
  - Previous (From) Carrier Suffix, if applicable. The carrier suffix code indicating the health plan in which the employee was previously enrolled. If this is the employee’s initial enrollment in the program, leave this field blank. (Refer to the *Monthly Coverage Report* for the carrier (plan) suffix codes.)
  - Effective Date - The month, day and year the coverage should be effective. (“Prospective Date of Coverage” field on the application.)
  - Contract Type - Coverage code identifying single or family coverage (and Medicare if applicable). Where single coverage is selected, enter the coverage code in the “Single” column; where family coverage is selected, enter the coverage code in the “Family” column. (“Coverage Type Code” field on the application.)
  - Premium Adjustment Previous Month(s), if applicable. Complete if the effective date is retroactive (i.e., prior to the coverage month being reported); otherwise leave blank.
    - a. Month - The month and year for any previous month(s) of coverage. For more than one previous month being reported, enter one month per line. For example, if the coverage month is May 2006, and the effective date for the addition was March 1, 2006, enter March 2006 on one line, and April 2006 on the next line.
    - b. Amount - Enter the premium amount for the previous month (one month per line) listed. (This will be a positive amount.)
- H. At the bottom of the report, total the Single and Family contract type columns and the Amount column. Post the totals to the *Monthly Coverage Report* as described in Subchapter 505.
- I. Attach “ETF Coverage Report Copy” of enrollment application for each contract listed on the additions report.

Below are examples of common situations recorded on the sample *Monthly Additions Report* that follows:

**Monthly Additions Report Examples**

Enrollment Type	Description of Situation
02	Terrance Anderson is a newly hired employee. <i>(Premium adjustments must be made to make premiums current.)</i>
03	Jane Doe returned from a leave of absence during which coverage lapsed. <i>(Multiple premium deductions must be made to make premiums current.)</i>
08	Kelly Johnson did not apply for coverage during initial enrollment period. She is limited to the Standard Plan option with a 180-day waiting period for all pre-existing conditions.
12	Sondra Williams was deleted in error on a previous month's report; coverage is continuous. <i>(Multiple premium deductions must be made to make premiums current.)</i>
31	Andrea Rodgers transferred coverage from her spouse, Kenneth Rodgers. <i>(No adjustment for previous month is necessary if the effective date is coordinated so there is no duplication or lapse in coverage.)</i>
40	Maria Rodriguez switched health plans during Dual Choice. <i>(No adjustment for previous month is necessary as long as the assignment of effective date is coordinated so that no lapse in coverage occurs. Indicate the health plan from which the employee is transferring.)</i>
41	Katie Swanson transferred plans due to a residential move. <i>(Addition must be coordinated with the deletion of the other plan. Indicate the plan from which the employee transferred.)</i>



### 503 Completing the *Monthly Deletions Report* (ET-2612)

The *Monthly Deletions Report* is used to report any contracts that have been deleted from each health plan. A separate report must be prepared for each health plan, every coverage month for which there are deletions, and may have supporting documents attached to it.

The following is a list of common deletion situations, the date coverage ends for each activity/transaction, the form(s) required in addition to the deletion report, and applicable comments or instructions:

#### DELETION SITUATIONS

<b>Activity/ Transaction</b>	<b>Effective Date</b>	<b>Form(s) Required</b>	<b>Adjustments/Refunds/Comments</b>
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 (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 continues through the last day of the month for which premiums have been paid.	<i>Continuation - Conversion Notice</i>	Do not refund any premiums unless authorized by ETF.
Cancellation of Coverage	Coverage continues through the last day of the month for which premiums have been paid.	<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 - 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.

<b>Activity/ Transaction</b>	<b>Effective Date</b>	<b>Form(s) Required</b>	<b>Adjustments/Refunds/Comments</b>
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.		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, the employer share for those months prepaid is to be refunded. (Refer to Subchapter 311.)  Premium payments must be received at least 30 days prior to the coverage month.
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.
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	End of the month that employer provides <i>Continuation - Conversion Notice</i> (Refer to Subchapter 703).	<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 to ETF within 60 days of the date of notice or with 60 days after coverage ends, 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.

To complete the *Monthly Deletions Report*, enter the following information:

- A. Employer Name.
- B. Employer Number - The employer identification number (EIN) is the number assigned to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**0001-114**)
- C. Group # - The five digit number assigned to State agencies (e.g., **84535**).

- D. 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 *Monthly Coverage Report*.)
- E. Deduction Month - Optional – Employer may use for internal purposes.
- F. Coverage Month - The month and year for which coverage is being reported.
- G. List employee last names--in alphabetical or social security number order--for each contract being deleted. Complete the following information:
- Enrollment Type/Code - The code identifies the reason for the deletion. (Refer to Subchapter 1104.)
  - Employee Type/Code.- Enter the appropriate code. (Refer to Subchapter 1103.)
  - Name (Last, First, Middle I) - Employee name in alphabetical order by last name or in numeric order by social security number.
  - Social Security No - List the employee's social security number.
  - Birthdate - The month, day and year of the employee's date of birth.
  - (To) Carrier Suffix, if applicable. The Carrier Suffix code (located on *Monthly Coverage Report*) indicating the health plan to which the employee is switching. If the employee is not switching health plans, leave this field blank.
  - Event Date - The month, day and year of the event resulting in the termination of coverage (e.g., the last day of employment, date of divorce, date of death, etc.).
  - Effective Date - The month, day and year following the last day of coverage. It is generally the first of the month.
  - Contract Type - The coverage code identifying the type of coverage. If the contract was for single coverage, enter the coverage code in the "Single" column; if the contract was for family coverage, enter the coverage code in the "Family" column. (Refer to Subchapter 1102.)
  - Premium Adjustment Previous Month(s), if applicable. Complete if the effective date is retroactive (i.e., prior to the coverage month being reported); otherwise leave blank. **Retroactive premium adjustments for months prior to January of the previous calendar year are prohibited.**

Example: Employee terminates employment in October 2005 with a coverage end date of October 31, 2005. However, premiums are remitted in error until March 2007. A premium adjustment retroactive to January 2006 is allowed although adjustments for November and December 2005 are not.

- a. Month(s). Enter the month and year for the previous month(s) of coverage. If there is more than one previous month being reported for

retroactive adjustment, enter one month per line. For example, if the coverage month is May 2006, and the effective date for the deletion is March 1, 2006, enter March 2006 on a line, and April 2006 on the next line.

- b. Amount. Enter the premium amount for the previous month(s) listed. (This will be a negative amount.)

H. At the bottom of the report, total the Single and Family contract type columns and the Amount column. Post the totals to the *Monthly Coverage Report* as described in Subchapter 505.

Below are examples of situations that are recorded on the sample *Monthly Deletions Report* that follows:

#### Monthly Deletions Report Examples

Enrollment Type	Description of Situation
03	Jeanne Moore is on leave of absence and allows coverage to lapse.
09	Valerie Hughes voluntarily cancels coverage. ( <i>Premiums paid in advance can be refunded if employer receives the written request by the end of the preceding month.</i> ) Attach application indicating cancellation.
10	Jeffrey Andrews terminated employment and did not apply for WRS benefit.
11	Alan Goodman died; he had single coverage. ( <i>Adjustment is made for refund of premiums paid beyond the month of death.</i> )
31	Kenneth Rodgers transferred to the contract of his spouse, Andrea Rodgers, a fellow employee. ( <i>Transfer/deletion must be coordinated with transfer/addition (change) on spouse's contract.</i> )
40	Robin Michaels switched to another health plan during Dual-Choice. ( <i>Indicate health plan to which employee is transferring and list the employee on the Monthly Additions Report for that health plan.</i> )
50	Thomas Smith retired. ( <i>If retired employee is coded "10" rather than "50" conversion material will be incorrectly sent by the health plan. This could result in annuitant not having correct insurance coverage.</i> )

Monthly Deletions Report Sample

Department of Employee Trust Funds 801 W. Badger Road P.O. Box 7931 Madison, Wisconsin 53707-7931										<b>GROUP HEALTH INSURANCE</b> <b>MONTHLY DELETIONS REPORT</b> <small>Wis. Stats. § 40.06, 40.51 (7)</small>		Enrollment Indicator <b>4</b>	
Employer Name <b>State Agency ABC</b>			Employer Number <b>69-036-0001-199</b>		Group # <b>84999</b>		Carrier Suffix <b>01</b>		Deduction Month <b>Feb 2006</b>				
Enrollment Type Code	Name (Last, First, Middle I.)	Social Security No.	Birthdate	If changing carrier, provide new carrier suffix	Event Date	Effective Date	Contract Type		PREMIUM ADJUSTMENT PREVIOUS MONTH(S) (List individual months)				
							Single	Family	Month(s)	Amount			
10 02	Andrews, Jeffrey W.	012-34-5678	07-10-64		12-31-05	01-01-06	01		Jan 06	(762.60)			
11 02	Goodman, Alan L.	123-45-6789	09-15-52		11-12-05	12-01-05		02	Dec 05	(1862.40)			
	"								Jan 06	(2017.70)			
09 02	Hughes, Valerie K.	234-56-7890	02-15-72		01-31-06	02-01-06		02					
40 02	Michaels, Robin E.	456-78-9012	06-30-61	22		01-01-06		02	Jan 06	(2017.70)			
03 02	Moore, Jeanne A.	567-89-2013	04-21-68		01-10-06	02-01-06		02					
31 02	Rodgers, Kenneth T.	678-90-1234	01-27-63			02-01-06		02					
50 02	Smith, Thomas M.	789-01-2345	02-02-50		01-21-06	02-01-06		02					
TOTAL DECREASE IN CONTRACTS									1	6	(6,660.40)		

(Post to Line 3 of the Monthly Coverage Report)

See your Health Insurance Administration Manual for detailed instructions.

**504 Completing the *Monthly Changes Report* (ET-2614)**

The *Monthly Changes Report* is used to report coverage changes (family to single/single to family) **within each health plan**. A separate report must be prepared for each health plan, every coverage month for which there are changes, and should have applications or other supporting documents attached to it. Changes affecting the level of coverage must be reported on the *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302).

**NOTE: A change in coverage does not create an opportunity to switch health plans. (The Dual-Choice Enrollment period is one exception to this. For Dual-Choice elections resulting in a change in coverage and a switch in health plans, do not utilize the *Monthly Changes Report*. Instead, you must report the deletion on the *Monthly Deletions Report* (ET-2612) for the health plan for which coverage is being deleted, and report the addition on the *Monthly Additions Report* (ET-2610) for the health plan for which coverage is being added.)**

The following is information on common change situations, which must be reported using the *Group Health Insurance Application* and included on the *Monthly Changes Report*:

**COVERAGE CHANGE SITUATIONS**

Activity/ Transaction	Effective Date	Adjustments/Refunds/Comments
Death of Sole Dependent	Single coverage takes effect first day of month following death.	Refund difference between family premium and single premium retroactive to effective date. Retroactive refunds are not allowed for coverage months prior to the beginning of the previous calendar year.
Marriage (Employee)	When first becoming eligible for family coverage, effective the date of marriage if application received within 30 days of marriage.  OR First day of month following receipt of application.*	If marriage took place on or before the 15th of the month, a family premium is due for that month. If marriage took place on or after the 16th of the month, a family premium is not due until the following month. Collect difference between single premium and family premium retroactive to effective date.

Activity/ Transaction	Effective Date	Adjustments/Refunds/Comments
Divorce	<p>For divorced spouse, first day of month following date divorced spouse is provided <i>Continuation - Conversion Notice</i> (ET-2311)</p> <p>For other dependents, first day of month following date divorce is entered or notification is received, whichever is later.</p>	<p>If divorced spouse was the sole dependent and any children are step-children, employee's single coverage is effective on the first of the month following divorced spouse being provided <i>Continuation - Conversion Notice</i>. Refund difference in premium retroactive to effective date. An employee's divorced spouse and stepchildren are eligible for continuation-conversion of coverage if an application is received by ETF within 60 days of the date of notice or within 60 days after coverage ends, whichever is later (see Chapter 7). If the divorced spouse is also a state employee, he or she may assume coverage.</p> <p>Dependent children (not step-children) of a divorced employee are eligible for coverage under the employee's family contract even if the children reside elsewhere or are supported by the divorced spouse.</p>
Adding newborn dependent when single coverage is in force	<p>Date of birth if application is received within 60 days of the birth.</p> <p style="text-align: center;">OR</p> <p>First day of month following receipt of application.*</p>	<p>If the date of birth falls on or before the 15th of the month, a full family premium is due for that month. If the date of birth falls on or after the 16th of the month, a full family premium is not due until the next month.</p>
<p>*An application to change from Single to Family coverage, filed within 30 days (60 days for birth or adoption) after first becoming eligible for family coverage, is effective retroactive to the date the event (e.g., marriage, etc.) occurred. If filed later, coverage is effective the first of the month following receipt of the application and is limited to the Standard Plan, with a 180-day waiting period for pre-existing conditions for newly added dependents.</p>		

Enter the following information to complete the *Monthly Changes Report*:

- A. Employer Name.
- B. Employer Number - The employer identification number (EIN) is the number assigned to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**0001-114**)
- C. Group # - The five digit number assigned to State agencies (e.g., **84999**).
- D. 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 plan suffix codes.)

- E. Deduction Month - Optional – Employer may use for internal purposes.
- F. Coverage Month - The month and year for which coverage is being reported.
- G. List employee last names—in alphabetical or social security number order—for which coverage is changing and complete the following information:
- Enrollment Type - This code identifies the reason for the deletion. (“Enrollment Type Code” field on the application.)
  - Employee Type - Enter the appropriate code. (Refer to Subchapter 1103.)
  - Name Last, First, Middle I - Employee name in alphabetical order by last name or in numeric order by social security number.
  - Social Security No - List the employee’s social security number.
  - Effective Date of Change - The month, day and year the change in coverage is effective.
  - Type of Contract.
    - a. From - Enter the coverage code under the column indicating the type of coverage from which the employee is switching.
    - b. To - Enter the coverage code under the column indicating the type of coverage to which the employee is switching. (“Coverage Type Code” field on the application.)
  - Premium Adjustment Previous Month(s), if applicable. Complete if the effective date is retroactive (i.e., prior to the coverage month being reported); otherwise leave blank.

Note: Retroactive premium adjustments for months prior to January of the previous calendar year are prohibited for contracts changing from family to single coverage. Retroactive premium adjustments for changes of single to family coverage are allowed back to the effective date of family coverage.

- a. Month - Enter the month and year for the previous month(s) of coverage. If there is more than one previous month being reported for retroactive adjustment, enter one month per line. For example, if the coverage month is May 2006, and the effective date for the coverage change is March 1, 2006, enter March 2006 on one line, and April 2006 on the next line.
- b. Amount - Enter the premium amount for the previous month(s) listed. In computing adjustment amounts when changing from single to family or family to single, calculate the difference between the total single premium and the total family premium, and either add or subtract that difference for each month that requires an adjustment. If the premium adjustment amount is to

be decreased, post it in parentheses.

For example, using 2006 rates for Standard Plan:

\$2,017.70 Family  
 - 808.50 Single  
 \$1,209.20 Adjustment

H. At the bottom of the report, total the From and To contract type columns and the Amount column. As described in Subchapter 505, post the totals to the *Monthly Coverage Report*. If the total premium adjustment amount is negative, post the total in parentheses.

Below are examples of situations that are recorded on the *sample Monthly Changes Report* that follows:

**Monthly Changes Report Examples**

Enrollment Type	Description of Situation
43	Tyler Knot changed from single to family coverage due to marriage on the 16 <sup>th</sup> of the previous month. <i>(Date of marriage was after the 15th of the month; therefore, premium for January remains the single coverage rate.)</i>
43	Rochelle Thompson changed from single to family coverage due to marriage on the 14 <sup>th</sup> of the previous month. <i>(Date of marriage was on or before the 15<sup>th</sup> of the month; therefore, premium for January is the family coverage rate.)</i>
44	George Miller changed from family to single coverage due to death of his spouse on the 18 <sup>th</sup> of the previous month.
44	On November 14 <sup>th</sup> , Sarah Taylor reported that her divorce was final on October 28 <sup>th</sup> ; there are no other eligible dependents. <i>(Provide the Continuation-Conversion Notice (ET-2311) to the ex-spouse.)</i>
45	Edward Daniels voluntary changed from family to single coverage as the dependent(s) remains eligible.
66	Error made on December coverage report. Rosalie Hernandez reported for incorrect type of contract. Adjustment is made for the difference in the two months' premium. <i>(Attach memo from ETF authorizing correction.)</i>



## 505 Completing the *Monthly Coverage Report* (ET-1607)

The *Monthly Coverage Report* is used to summarize the net change in coverage for each reporting month based on the monthly additions, monthly deletions, and monthly changes reports for each health plan in which employees are enrolled.

When completing the *Monthly Coverage Report*, employers should first verify that they are utilizing the correct form (provided by ETF) for the program option in which they are enrolled. Enter the following information to complete the *Monthly Coverage Report*.

- A. Employer No. (EIN) - The employer identification number (EIN) is the number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**0001-114**).
- B. Deduction Month - Optional - Employers may use for internal purposes.
- C. Coverage Month - The month and year for which coverage is being reported.
- D. Suffix - Two-digit code that identifies the health plan (carrier), being reported. It is sometimes referred to as the carrier code or plan suffix code.
- E. Employer Name.
- F. Group No - The five digit number assigned to State agencies (e.g., **84999**).
- G. **Line 1, Contracts in Effect Last Month** - Number brought forward from Line 6 of the previous month's *Monthly Coverage Report*. (The contract numbers from line 6 (Contracts in Effect This Month) on the previous *Monthly Coverage Report* **must be used** on line 1 (Contracts in Effect Last Month) on the current *Monthly Coverage Report*).
- H. **Line 2, Additions Report: (+)** - Post the total counts from *the Monthly Additions Report* (ET-2610) in the appropriate contract type column. Put a dash (-) in the field if there are no additions to report.
- I. **Line 3, Deletions Report: (-)** - Post in parentheses the total counts from the *Monthly Deletions Report* (ET-2612) in the appropriate contract type column. Put a dash (-) in the field if there are no deletions to report.
- J. **Line 4, Changes Report: "To" (+)** - Post the total counts from the To column of the *Monthly Changes Report* (ET-2614) in the appropriate contract type column. Put a dash (-) in the field if there are no "To" changes to report.
- K. **Line 5, Changes Report: "From" (-)** - Post in parentheses the total counts from the From column of the *Monthly Changes Report* in the appropriate contract type column. Put a dash (-) in the field if there are no "From" changes to report.
- L. **Line 6, Contracts in Effect This Month** - Add the numbers in Lines 1 through 5 of the column, except for those numbers in parentheses. Then subtract the numbers in

parentheses (deletions). Post the total in the appropriate contract type column.

- M. **Line 8, Subtotals (No. of Contracts x Premiums)** - Multiply the number of contracts on Line 6 by the premium rate shown for the health plan in Line 7.
- N. **Line 9, Subtotal** - The sum of the amounts in Line 8.
- O. **Line 10, Adjustments** - Calculate the total net adjustments from the monthly additions, deletions and changes reports by adding the amount from the total line of the additions report, subtracting the amount from the total line of the deletions report and adding/subtracting the amount from the total line on the changes report. The result can be a positive or negative amount. If it is a negative amount, post it in parentheses.

**NOTE: ETF will notify the employer via telephone call, e-mail or memo when an adjustment is needed because of a reporting error. These corrections should be included on the next monthly report, using a copy of the e-mail or memo as a supporting document. No retroactive adjustments will be made for coverage prior to the beginning of the previous calendar year.**

- P. **Line 11, Grand Total** - The sum of Lines 9 and 10. (Remember to subtract Line 10 from Line 9 if Line 10 is a negative amount shown in parentheses.)
- Q. **Line A, Total employee share of the premiums. This amount must include the employee share of any adjustment appearing on line 10.**
- R. **Line B, Total employer share of the premiums. This amount must include the employer share of any adjustment appearing on line 10.**
- S. **Line C, Sum of Lines A and B. The amount in Line C must equal the Grand Total on Line 11.** Post the amounts from Lines A, B and C on the *Health Insurance Summary* as described in Subchapter 506.

**NOTE: For reporting purposes, adjustments must be broken down between the employee and employer share.**

**EXAMPLE:** An employee changes from single to family contract under the Standard Plan. An adjustment for the difference in premiums is required, which would be shown in the Premium Adjustment column of the *Monthly Changes Reports*.

1. Using the 2006 rates for Standard Plan, the premium adjustment would be calculated by taking the difference between the single premium and the family premium.

\$2,017.70 Family
- <u>808.50</u> Single
<b>\$1,209.20 Total Adjustment</b>

2. The *Monthly Coverage Report* requires a breakdown of the employer and employee share of any premium adjustment. Using 2006 employees share amounts (Standard Plan single rate - \$100.00; family rate - \$250.00) for a contract going from single to family coverage and requiring an adjustment:

Employee share of the new family coverage	\$250.00
Less employee share of the former single coverage	<u>\$100.00</u>
The amount of employee share that must be included In line A for this one month adjustment	\$150.00

3. Double-check your adjustment figures for accuracy by adding the employee share adjustment and the employer share adjustment; the sum should match the adjustment on the *Monthly Changes Report*.
  4. Make the necessary adjustment to the employee and employer share amounts for the appropriate health plan on the *Monthly Coverage Report*.
- T. Date (MM/DD/CCYY) - The date the report was completed.
- U. Prepared By - The signature of the person who prepared the report.
- V. Telephone - The telephone number of the person who prepared the report.
- W. Attach the monthly additions, deletions and changes reports for the health plan along with any supporting documentation. (Refer to Subchapter 507 for more information about assembling the reports upon completion.)

**NOTE: The coverage types of Single Medicare, Family Medicare–2 and Family Medicare-1 are not listed on the *Monthly Coverage Report* for active employees because active employees are not eligible for the Medicare reduced rates.**

Following is a completed sample *Monthly Coverage Report* based on the information from the sample additions, deletions and changes reports in this chapter. For quick reference, the parts of the sample form shown that would vary, depending on the form number used, are shaded.

Monthly Coverage Report Sample

Employee Trust Funds Group Health Insurance		Employer No. (EIN) 69-036-0001-199	Deduction Month	Coverage Month Feb 2006	Suffix 01
<b>STATE EMPLOYEES PGM OPT P01 &amp; SRCHG S01 2006 MONTHLY COVERAGE REPORT</b>		Employer Name <b>State Agency ABC</b>			Group No. <b>84999</b>
		Single Contracts	Family Contracts	Grad. Asst. Single Contracts	Grad. Asst. Family Contracts
<b>1 Contracts in Effect Last Month:</b>		<b>5</b>	<b>10</b>		
<b>2 Additions Report: (+)</b>		<b>3</b>	<b>4</b>		
<b>3 Deletions Report: (-)</b>		<b>(1)</b>	<b>(6)</b>		
<b>4 Changes Report "To": (+)</b>		<b>3</b>	<b>3</b>		
<b>5 Changes Report "From": (-)</b>		<b>(3)</b>	<b>(3)</b>		
<b>6 Contracts in Effect This Month:</b>		<b>7</b>	<b>8</b>		
<b>7 Plan</b>	<b>Suffix</b>				
Standard Plan	.01	808.50	2017.70	609.10	1519.40
State Maintenance Plan (SMP)	.05	511.30	1275.00	387.10	964.50
CompcareBlue Southeast	.11	586.40	1462.60	387.40	965.10
CompcareBlue Northwest	.13	561.10	1399.40	369.70	920.90
Dean Health Plan	.15	437.60	1090.80	283.30	704.90
CompcareBlue – Aurora/Family	.16	495.60	1235.80	323.80	806.10
Humana – Eastern	.21	571.60	1425.60	401.80	1001.10
Humana – Western	.22	571.50	1425.40	401.70	1000.90
GHC - Eau Claire	.30	525.00	1309.10	366.80	913.60
GHC - South Central	.35	430.20	1072.10	283.00	704.10
Gundersen Lutheran	.37	532.40	1327.80	327.50	815.40
Unity – Community	.40	546.40	1362.60	350.00	871.60
WPS Prevea Health Plan	.47	512.60	1278.10	335.70	835.90
Health Tradition	.55	535.20	1334.60	352.30	877.40
Medical Associates HMO	.63	443.40	1105.10	287.30	714.90
MercyCare Health Plan	.64	402.80	1003.80	242.60	603.10
Network Health Plan	.70	465.40	1160.10	283.40	705.10
Physicians Plus – Meriter & UW	.74	439.30	1094.90	302.60	753.10
WPS Patient Choice Plan 1	.81	555.00	1384.10	375.00	934.10
WPS Patient Choice Plan 2	.82	601.50	1500.40	408.50	1017.90
United Healthcare – Southeast	.83	531.20	1324.60	370.80	923.60
Unity - UW Health	.92	435.30	1084.90	274.50	682.90
UnitedHealthcare –Northeast	.94	448.60	1118.10	309.20	769.60
<b>8. Subtotals (No. of Contracts x Premiums)</b>		<b>8a 5,659.50</b>	<b>8b 16,141.60</b>	<b>8c</b>	<b>8d</b>
<b>A. Employee Share =</b>	<b>3,250.00</b>	<b>(8a + 8b + 8c + 8d)</b>			
<b>B. Employer Share =</b>	<b>22,902.50</b>	<b>9. Subtotal 21,801.10</b>			
<b>C. Total * (Lines A + B) =</b>	<b>26,152.50</b>	<b>10. Adjustments 4,351.40</b>			
		<b>(Line 9 + Line 10)</b>			
		<b>11. GRAND TOTAL* 26,152.50</b>			

\* NOTE: Figure entered on line C must equal figure entered on line 11.  
 \*\* NOTE: Figure entered must correspond to this plan's entry on the summary.

Date (MM/DD/CCYY) 01/18/06	Prepared By Betty Lou Payroll	Telephone 608-123-1444
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## 506 Completing the *Health Insurance Summary* (ET-1608)

The *Health Insurance Summary* is used to report total premiums by employee share and employer share, for each health plan summarizing the results of the *Monthly Coverage Reports* for each coverage month.

To complete the *Health Insurance Summary*, enter the following information:

- A. Employer Name.
- B. Employer No. (EIN) - The employer identification number (EIN) is the number assigned to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**0001-114**).
- C. Coverage Month - The month and year for which coverage is being reported.
- D. Plan - For each health plan in which employees are enrolled, enter the amount of employee share and employer share of the premium and total premium for the contracts for the health plan, as computed on Lines A, B, and C or 11 respectively of the corresponding *Monthly Coverage Report*.
- E. Subtotal Alt. Health - The sum of the amounts entered in each column for the health plans.
- F. Enter the amount of employee and employer share of the premium and total premium for the contracts for the Standard Plans and SMP, as computed on Lines A, B, and C or 11 respectively of the corresponding *Monthly Coverage Report*.
- G. Subtotal Std. Health - The sum of the amounts entered in each column for the Standard Plans and SMP.
- H. Enter the monthly Employee Reimbursement Account program administration fee. To arrive at this number, multiply the number of health insurance contracts—the total number of contracts from Line 6 of *Monthly Coverage Reports* less the number of contracts of employees not eligible for state share of health insurance premium—by the monthly ERA administration fee. The current (2006) fee is \$.60/contract/month and may be adjusted annually. (You must report and pay your agency's share of the program's administrative costs even if none of your employees are enrolled in the ERA program.)
- I. Grand Totals (Health & ERA) - The sum of the amounts calculated in the Subtotal Alt. Health and Subtotal Std. Health rows.
- J. Date (MM/DD/CCYY) - The date the report was completed.
- K. Prepared By - The signature of the person who prepared the report.
- L. Telephone - The telephone number of the person who prepared the report.
- M. Submit this form along with the other monthly reports as described in Subchapter

507.

Following is a sample *Health Insurance Summary* completed based on the information from the sample *Monthly Coverage Report* in this chapter. For quick reference, the parts of the sample form shown that would vary depending on the form number used, are shaded.

**Health Insurance Summary Sample**

Department of Employee Trust Funds  
 801 W. Badger Road, Madison, WI 53702-0011  
 State of Wisconsin Group Health Insurance

**STATE HEALTH INSURANCE SUMMARY – 2006  
 PGM OPT P01 & SRCHG S01**

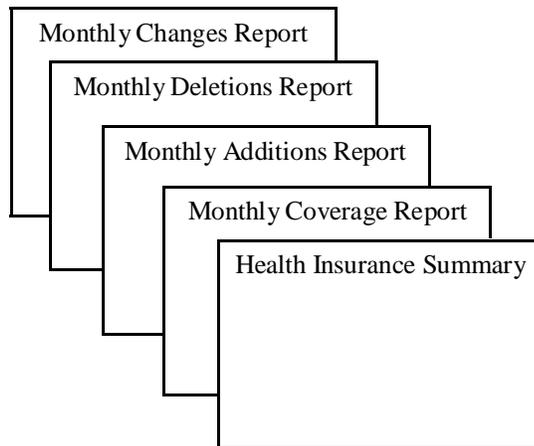
EMPLOYER NAME State Agency ABC		EMPLOYER NO. (EIN) 69-036-0001-199	COVERAGE MONTH FEB 2006	
PLAN	SUFFIX NO.	EMPLOYEE SHARE	EMPLOYER SHARE	TOTAL
CompcareBlue Southeast	.11			
CompcareBlue Northwest	.13			
CompcareBlue Northeast	.14			
Dean Health Plan	.15	770.00	14,512.00	15,282.00
CompcareBlue – Aurora/Family	.16			
Humana-Eastern	.21			
Humana-Western	.22			
GHC - Eau Claire	.30			
GHC - South Central	.35			
Gundersen Lutheran	.37			
Atrium Health Plan	.39			
Unity-Community	.40			
WPS Prevea Health Plan	.47			
Health Tradition	.55			
Medical Associates HMO	.63			
MercyCare Health Plan	.64			
Network Health Plan	.70			
Physicians Plus – Meriter & UW	.74	1,155.00	21,858.00	23,013.00
WPS Patient Choice Plan 1	.81			
WPS Patient Choice Plan 2	.82			
UnitedHealthcare – Southeast	.83			
Unity - UW Health	.92			
UnitedHealthcare – Northeast	.94			
<b>SUBTOTAL ALT. HEALTH</b>		<b>1,925.00</b>	<b>36,370.00</b>	<b>38,295.00</b>
Standard Plan	.01	3,250.00	22,902.50	26,152.50
State Maintenance Plan (SMP)	.05			
<b>SUBTOTAL STD. HEALTH</b>		<b>3,250.00</b>	<b>22,902.50</b>	<b>26,152.50</b>
<b>Total Health (Alt. &amp; Std.)</b>		<b>5,175.00</b>	<b>59,272.50</b>	<b>64,447.50</b>
<b>ERA Administration Fee</b>				<b>39.00</b>
<b>GRAND TOTAL (Health &amp; ERA)</b>				<b>64,486.50</b>

Date (MM/DD/CCYY) 01/18/06	Prepared By Betty Lou Payroll	Telephone 608-123-1444
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State Agencies: Write or type PV Numbers. Send no paper PV's to ETF. (Use back of form if needed.)

## 507 Assembly of Health Insurance Reports

To ensure prompt and efficient processing of reports by ETF and health plans, it is important to assemble your reports into the following two distinct sets:



### A. ETF set (in the following order):

1. The *Health Insurance Summary* with either a list of the WISMART PVs created for payment or an actual check (for those agencies that pay by check).
2. *Monthly Coverage Reports* for each health plan indicated on the *Health Insurance Summary* in the order that health plans appear on the *Health Insurance Summary*. Any corresponding monthly reports should be attached (stapled in the upper left corner) to the *Monthly Coverage Report* in the following order:
  - a. *Monthly Additions Report* (ET-2610) and *Group Health Insurance Application* (ET-2301 or ET-2302 for Graduate Assistants) for each addition in the order they appear on the additions report.
  - b. *Monthly Deletions Report* (ET-2612) and supporting documents.
  - c. *Monthly Changes Report* (ET-2614) and applications and/or supporting documents.

### B. Health Plan set (in the following order):

1. A photocopy of the *Health Insurance Summary* (with check stub or a photocopy of the check stapled behind it for those agencies paying by check). Note: Agencies remitting premiums payments through WISMART should not attach a list of PVs to the Health Plan set, but must attach a list to the ETF set.
2. Photocopies of the *Monthly Coverage Reports* for each health plan indicated on the *Health Insurance Summary* in the order that health plans appear on the *Health Insurance Summary*. Any corresponding reports with supporting documentation should be attached (stapled in the upper left corner) to the *Monthly Coverage Report* in the following order:

- *Monthly Additions Report*
- *Monthly Deletions Report*
- *Monthly Changes Report.*

Send both sets of reports to ETF. ETF will send the health plan to the plans.

## 508 Premium Remittance

A. State Agencies remit premiums using one of the following methods:

1. WISMART: Write/key the PV numbers on the *Health Insurance Summary* report or attach a list of the PV numbers. **Do not send a screen print of the WISMART page for each PV unless you only use one PV to remit payment.**
2. Check: Make your remittance check payable to “Employee Trust Funds” and clearly indicate the amount of the check along with the coverage month and year.

**NOTE: The check amount should include premiums collected from employees in a prepayment situation, such as on layoff, leave of absence or appealing a discharge. (Refer to Chapter 3 for more information.)**

In these situations, agencies will:

- Collect premiums from employees. These premium payments must be received by the employer at least 30 days prior to the end of the period for which premiums had previously been paid.
- Monitor internally employees who are prepaying premiums; collect the entire premium due from the employees.
- In the case of a leave of absence (LOA), discontinue prepayments after 36 months. If LOA is a union service leave, the eligibility period may differ; check union contract. Provide the employee with a *Continuation - Conversion Notice* (ET-2311) and include the employee on the *Monthly Deletions Report*.
- In the case of a layoff, discontinue prepayments after 60 months; provide the employee with a *Continuation - Conversion Notice* and include the employee on the *Monthly Deletions Report*.
- Allow employees appealing a discharge to continue prepayment until a final decision regarding the appeal is rendered.

If an employee on LOA maintains continuous coverage, ETF does not

need to know that the employee is making a prepayment; however, if the employee ceases prepaying premiums to you, he or she must be reported as a deletion (Enrollment Indicator 4, Enrollment Type 03). When the employee returns to work an application must be submitted to restore coverage. (See Chapter 3.)

B. Due Date

All group health insurance monthly **reports** and **remittances** are due in the ETF office on or before 4:30 p.m. on the **20th** day of the month preceding the month of coverage. When the 20th day falls on a Saturday, Sunday or holiday on which state offices are closed, the report is due by 4:30 p.m. on the next working day.

**Note:** For agencies remitting by WISMART, all PVs must be “approved” and all reports must be received by the dates noted above to avoid late filing interest charges. For agencies paying by check, both the check(s) and the reports must be received by the dates indicated above to avoid late filing interest charges.

EXAMPLE: The March 2006 (coverage month) report is due in ETF on Monday, February 20, 2006.

C. Interest Charge for Late Filing

Interest shall be charged on all **reports** and **remittances** received at ETF after the due date, at a rate of 0.04% (.0004 X the total remittance amount X the number of days beyond the due date that the report and remittance was actually received by ETF. There are no exceptions. The minimum charge is \$3.00. Wis. Stat. § 40.06(3) sets forth this requirement. ETF staff members do not have the authority to waive late interest charges.

D. Submitting Remittances and Reports

To ensure that your reports and remittances are **received** timely, you are encouraged to mail them at least five working days prior to the designated due date to reduce the likelihood of assessment of late filing charges. If remittances and reports are mailed through U.S. Mail or express mail carriers, address the envelope as follows:

Department of Employee Trust Funds  
Financial Operations  
PO Box 7931  
Madison WI 53707-7931

Reports and remittances which are delivered directly to ETF must be received prior to 4:30 p.m. on or before the designated due date. Dated receipts will be issued upon request for hand-delivered reports. If reports and remittance are being hand-delivered, please address the envelope as follows:

Financial Operations  
Division of Trust Finance & Employer Services  
801 W Badger Road  
Madison WI 53702

and deliver it to:

Department of Employee Trust Funds  
Supply & Mail Services  
801 W Badger Road  
Madison WI 53702

## **509 Credits**

Retroactive credits are not allowed for coverage months prior to the beginning of the previous calendar year. An exception is when the employee terminates employment and the employer continues to make premium payments, in which case, retroactive credits are limited to a maximum of the entire previous calendar year plus two months. Other exceptions may include cases of fraud, misrepresentation or unreported death. Please contact ETF for specific instructions in these instances.

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 6 – COBRA, CONTINUATION and CONVERSION**

- 601 Overview of COBRA, Continuation and Conversion**
- 602 Persons Eligible for Continuation (Qualified Beneficiaries)**
- 603 Employee Responsibilities**
- 604 Qualified Beneficiary Responsibilities**
- 605 Employer Responsibilities**
- 606 Notice Requirement Illustration Chart**
- 607 Continuation Coverage Information**
- 608 Instructions on Completing the *Continuation – Conversion Notice* (ET-2311)**
- 609 Sample *Continuation – Conversion Notice* (ET-2311)**

**601 Overview of COBRA, Continuation and Conversion**

Participants and their eligible dependents covered under the State Employee Group Health Insurance program have options available to them for the continuation of health insurance coverage in the event eligibility for group coverage ends. The following provides an overview of those options:

COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that the State Group Health Insurance program offer subscribers (employees) and their covered dependents temporary extension of coverage for a maximum of 36 months following specific events, referred to as “qualifying events,” as described in Subchapter 602. The extension of coverage allows subscribers and their covered dependents to continue receiving benefits identical to those provided to active employees at the group rate.

Continuation

Wisconsin statutes (Wis. Stat. §40.51 (3-4), § 632.897) allow subscribers and their covered dependents to continue their coverage for up to 18 months following specified events. This right to continue coverage allows subscribers and their covered dependents to receive benefits identical to those provided to active employees at the group rate.

**NOTE: Where Federal (COBRA) and State (continuation) law differ, the law most favorable to the participant will apply. When used in this chapter, “continuation” refers to the State or Federal legislation resulting in the most favorable outcome to the participant, unless otherwise specified.**

### Conversion

Conversion coverage is available to participants who have been covered under the State Employee Group Health Insurance program for at least three months upon termination. Participants may elect to convert to individual (non-group) coverage upon the loss of eligibility for group coverage, i.e., when they reach the maximum length of continuation of group coverage or in lieu of continuation coverage. Participants electing conversion coverage do not need to provide evidence of insurability (i.e. be underwritten) but must apply within 30 days after group coverage terminates. The benefits and rates for conversion coverage are different than the benefits and rates for continuation coverage. Employees should contact the health plan with questions regarding conversion.

## **602 Persons Eligible for Continuation (Qualified Beneficiaries)**

Under Federal law, when group health insurance coverage would otherwise end because of a life event known as a “qualifying event,” employees and their covered spouse and dependent children become “qualified beneficiaries” and must be offered continuation coverage. (Refer to Subchapter 605 for employer responsibilities.)

- A. Employees must be offered continuation coverage in the event coverage is lost due to either of the following events:
- Termination of employment (for reasons other than gross misconduct), including retirement. The exception is when an employee retires and elects to take an immediate annuity and continue health insurance. (Refer to Chapters 7 and 8.)
  - Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff (Refer to Subchapters 312 and 313).
- B. The spouse of an employee with family coverage in the State Employee Group Health Insurance program becomes a qualified beneficiary as a result of any of the following qualifying events:
- Death of spouse (employee). (Refer to Chapter 10 on Employee Death.)
  - Divorce. Coverage as a dependent spouse continues until the later of:
    - The end of the month in which the employer provides notification of continuation rights (*Continuation - Conversion Notice* [ET-2311]). (Refer to Subchapter 603.)
    - OR
    - The end of the month in which the divorce is entered/final.
  - Spouse (employee) loses coverage for reasons listed above in A.
- C. Each eligible dependent child of an employee with family coverage in the State Employee Group Health Insurance program becomes a qualified beneficiary as a result of any of the following qualifying events:

- Death of parent/step-parent (employee). (Refer to Chapter 10 on Employee Death.)
  - Dependent eligibility status ceases under the State Group Health Insurance program. (Refer to the chart in Subchapter 606 for examples.)
  - Parents become divorced resulting in loss of eligibility.
  - Parent (employee) loses coverage for reasons listed above in A.
- D. An eligible dependent grandchild of an employee with family coverage in the State Group Health Insurance program becomes a qualified beneficiary when losing eligibility as a result of the dependent child (grandchild's parent) turning age 18. Coverage for the grandchild terminates at the end of the month in which the dependent child turns 18.
- E. An eligible disabled dependent, over age 19, of an employee with family coverage in the State Group Health Insurance program becomes a qualified beneficiary upon loss of disabled status. Coverage terminates at the end of the month in which it is determined the disabled status ceases.

**NOTE: When a voluntary change in coverage from a family plan to a single plan is done in anticipation of a divorce, the spouse and dependent children are eligible for continuation coverage when the divorce is final. The effective date for continuation coverage in this case is the date of the divorce. In all other cases, voluntary cancellation does not create a continuation enrollment opportunity.**

### 603 Employee Responsibilities

Employees and/or the qualified beneficiaries (Refer to Subchapter 602) are responsible for informing the employer of a qualifying event in which an employee and/or dependent loses eligibility for coverage under the State Group Health Insurance program. Under Federal COBRA law, if the employer is not notified within 60 days of (1) the event that caused the loss of coverage, or (2) the end of the period of coverage, whichever is later, the right to continuation coverage is lost. Under State continuation law, separate requirements may allow notification after the 60-day period in limited divorce circumstances.

In the event of a divorce, if an employee does not advise their employer of their divorce, coverage for the ex-spouse and any stepchildren continues if the family premium continues to be paid. The ex-spouse must then be given the right to continue coverage even if notice is given beyond 60 days following the divorce. Should the employee fail to advise the employer of divorce within 60 days of the event, the employer must provide notice to stepchildren that they are ineligible to continue coverage as a qualified beneficiary of the employee. Coverage terminates the end of the month in which the employer provides the notice of the right to continue coverage (*Continuation -*

*Conversion Notice* (ET-2311) to the ex-spouse and any stepchildren. In this situation, employers must check with ETF on the length of continuation coverage that is available.

Note: The ex-spouse is eligible to continue coverage under a single contract or a family contract with eligible dependents. The stepchildren are not eligible to continue coverage under a single contract of their own because notice of the divorce was not given to the employer within 60 days of the divorce. If the stepchildren meet the criteria of being an eligible dependent and the ex-spouse applies for family coverage as a continuant, the stepchildren can be included as covered dependents on the ex-spouse's family contract.

## 604 Qualified Beneficiary Responsibilities

Qualified beneficiaries are responsible for the following when electing continuation or conversion coverage:

- Submitting the *Continuation - Conversion Notice* (ET-2311) and the *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302) to ETF. Both forms (an employee need only submit a *Continuation - Conversion Notice* unless requesting a change in coverage) must be sent to ETF (i.e., postmarked) **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**. If qualified beneficiaries do not elect continuation coverage within the 60-day period, their coverage under the State Group Health Insurance program will end.
- Paying premium to the health plan when billed by the health plan.
- Reporting any changes affecting coverage, for example, address change, birth or adoption. If continuation coverage is elected, changes must be reported to ETF; if conversion coverage is elected, changes must be reported to the health plan.
- Subscribers and their insured dependents continuing coverage must enroll in Medicare Part A and B when first eligible. A copy of the Medicare card must be submitted to ETF.

## 605 Employer Responsibilities

**Within 5 days of being notified of the "qualifying event,"** the employer is responsible for providing the following documents to qualified beneficiaries notifying them of their right to continue group coverage or convert to individual coverage:

- *Continuation - Conversion Notice* (ET-2311), with the employer sections completed as described in Subchapter 608.
- *Group Health Insurance Application* (ET-2301; Graduate Assistants, ET-2302). This form is needed to enroll in continuation or conversion. However the employee does not need to complete the application if continuing the coverage already in effect.

The employee must still complete and return the *Continuation - Conversion Notice*.

**NOTE: A continuation notice be provided within the 5 period even when it is determined the qualified beneficiary is not entitled to continuation coverage (for example, notice of the qualifying event was not provided to the employer within the required time period). (Refer to Subchapter 608 for information on providing notice.)**

The employer is responsible for informing qualified beneficiaries of the following:

- If electing continuation coverage, the completed *Continuation - Conversion Notice* and *Group Health Insurance Application* forms must be sent to ETF (i.e., postmarked) **no later than 60 days after the date of the notice or 60 days after coverage ends, whichever is later.**
- If electing continuation coverage, the health plan will bill the continuant(s) directly.
- If electing continuation coverage and the continuants are moving or will move to a different county for more than 3 months, they are eligible to transfer to another health plan without restrictions, provided the application is received within 30 days after the move. The application must be returned to the employer if the change would be effective before the termination of coverage paid through the employer; otherwise, the application must be returned to ETF. If the application is not received within 30 days after the move, coverage is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.

**Note: When completing the monthly health insurance reports (refer to Chapter 5), the employer must remove terminated employees from active coverage effective the end of the month through which premiums are paid regardless of whether the employee elects COBRA or not.**

## 606 Notice Requirement Illustration Chart

The following chart illustrates a timetable for providing notices related to continuation coverage for common scenarios:

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Child turns 19 and is not a full-time student.	3/15/06	12/31/06	3/1/07	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Grandchild Eligibility Ends as Child-Parent turns 18	6/10/06	6/30/06	8/29/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer

Event	Occurs	Coverage Continues Until	Employee or Beneficiary Must Notify Employer By	Employer Must Provide Continuation Notice By	To Elect Continuation, Application Must Be Submitted To ETF By
Student Status Terminates for 20-Year Old Dependent	6/2/06	12/31/06	3/1/07	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Divorce Decree is Entered	04/03/06	End of the month in which continuation notice is given	06/02/06 If continuation notice is given late, check with ETF	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Plan Determines Dependent Over Age 19 No Longer Meets Disabled Status	8/25/06	8/31/06	10/30/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice from employer
Dependent Marries	5/7/06	5/31/06	7/30/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice from employer
Employee Terminates Employment	6/16/06	7/31/06	9/29/06	5 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer

## 607 Continuation Coverage Information

The benefits and limitations of coverage under continuation are identical to those provided to active employees. Participants enrolled in continuation coverage (continuants) must select the health plan already in effect at the time of termination of active coverage. Should the qualified beneficiary not reside in the same county as the subscriber, the qualified beneficiary may elect a health plan in their county of residence when enrolling in continuation coverage, even if the subscribers health plan is available in the qualified beneficiary's county. Continuants are allowed to change health plans during the annual Dual-Choice Enrollment period or following a residential move out of the county.

Continuation coverage may be in effect for up to 36 months. However, continuation coverage may be terminated early for any of the following reasons and cannot be reinstated:

- The premium for continuation coverage is not paid when due.

- The subscriber becomes covered under another group health plan that does not restrict coverage for pre-existing conditions, for example, cancer, diabetes, etc. (A subscriber who refuses health insurance offered by another employer will not be affected.)
- A spouse is divorced from a covered employee and subsequently remarries and is covered through their new spouse's group health plan.
- Qualified beneficiary voluntarily cancels continuation coverage.

Continuants may elect to convert to individual coverage (conversion at non-group rates) upon reaching the maximum continuation coverage period. Continuants are responsible for knowing when group continuation coverage ends and must contact their health plan directly to make application for conversion coverage within 30 days after group coverage terminates.

#### 608 Instructions on Completing the *Continuation - Conversion Notice* (ET-2311)

The employer must complete the employer portions of the *Continuation - Conversion Notice* before providing it to qualified beneficiaries. The following instructions describe the employer portions of the form:

- A. On the Instructions cover sheet, check the appropriate box indicating whether the qualified beneficiary is eligible to elect continuation coverage. For example, if the employer does not receive notice within 60 days following the termination of coverage for a dependent who married, the dependent is not eligible for continuation coverage.
- B. On the notice, complete the required information.
  - In the box located in the upper right hand corner, list the
    - a. Employee Social Security Number
    - b. Employee Name (Last, First)
    - c. Employee's Birthdate (MM/DD/CCYY)
    - d. Group #.
  - Complete the **Applicant/Qualified Beneficiary Information** by listing the address of the qualified beneficiary(ies) using the address indicated on the *Health Insurance Information Change* form (ET-2329) that is completed by the employee when deleting a dependent/former spouse when there are other eligible dependents. Deleting the sole dependent or all dependents constitutes a change from family to single coverage. In this case, the employee must complete a *Group Health Insurance Application* (ET-2301 or ET-2302 for Graduate Assistants) instead of the *Health Information Change* form.

Note: If the qualified beneficiaries are the former spouse and/or step-children whose deletion is the result of a divorce, a copy of the *Continuation - Conversion*

*Notice provided to the qualified beneficiaries must be attached to the Group Health Insurance Application or the Health Insurance Information Change form received from the employee and forwarded to ETF.*

- Identify the relationship of the qualified beneficiary(ies) to the employee by checking the following boxes that apply:
  - a. Employee
  - b. Spouse/Former Spouse
  - c. Dependent Child(ren)

List the name in the space provided of the Spouse/Former Spouse and name(s) of the Dependent Child(ren), when checking those boxes.

**NOTE: Per Federal COBRA law, notice is to be provided to each qualified beneficiary. For example, an employee with family coverage terminates employment; the employer must provide notice to all covered family members. When qualified beneficiaries reside at the same address, complete one notice indicating relationship and names of all qualified beneficiaries. When qualified beneficiaries reside at different addresses, complete one notice per address, indicating the qualified beneficiary(ies) residing at the address listed.**

- In the **To Be Completed by Employer Prior to Giving to the Applicant** box, list the following:

**Item 1:** If the qualified beneficiary(ies) is (are) not eligible to elect continuation coverage, explain the reason why. If the qualified beneficiary(ies) is (are) eligible for continuation coverage, leave blank.

**Item 2:** Enter the date the applicant/qualified beneficiary's coverage will end. This date will be as follows:

- a. Terminating Employee - The date through which the group health insurance premiums are currently paid.
- b. Divorced Spouse - The end of the month in which notice of continuation is given. (Refer to note in subchapter 602 if the employee voluntarily cancels family coverage in anticipation of the divorce.)
- c. Dependent Child - The date will be the end of the month in which the earliest of the following occurs:
  - Marries
  - Ceases to be dependent for support and maintenance, if over 19.

OR

The end of the calendar year in which the child:

- Turns 19 while not a full-time student.
- Ceases to be a full-time student and is older than 19.

- Turns 25 while still a full-time student.
- d. Dependent Grandchild - The end of the month in which the child (grandchild's parent) turns 18.
- e. Disabled Dependent over age 19 who loses disabled status - The end of the month in which it is determined the disabled status ceases.

**Item 3:** Identify the reason for coverage ending by checking the appropriate box and providing an explanation where requested.

**Item 4:** Enter the date (MM/DD/CCYY) of occurrence in Item 3.

**Item 5:** Enter the date (MM/DD/CCYY) the employer was notified of the occurrence in Item 3.

**Item 6:** Check the box indicating the type of coverage in effect at the time of occurrence in Item 3.

**Item 7:** Enter the name of the health plan in which the qualified beneficiary is currently enrolled and the full monthly premium rate for the coverage in effect.

**Item 8:** Enter the following information:

- a. Signature of the person completing the employer portions of the notice.
- b. Date (MM/DD/CCYY) the notice is given to the qualified beneficiary. For example: the date the notice is mailed to the qualifying beneficiary or the date the notice is physically handed to the qualifying beneficiary.
- c. Employer name and mailing address.
- d. Telephone number to contact the person completing the employer portions of the notice.

C. After completing the employer portions, retain the employer copy of the *Continuation - Conversion Notice* for your records and forward the remaining copies to the qualified beneficiary(ies) along with the *Group Health Insurance Application*. (Refer to Subchapter 604.)

If, on the basis of the most recent information available to the employer, the qualified beneficiaries reside at the same location as the employee, the employer may furnish to the employee the notice addressed to the qualified beneficiaries. If the qualified beneficiaries reside at a location different than that of the employee, the employer must mail the notice to the qualified beneficiaries.

**609 Sample *Continuation - Conversion Notice* (ET-2311)**

Following is a sample *Continuation - Conversion Notice* that has been completed for a 22-year old dependent whose eligibility ended due to marriage and the dependent is ineligible for continuation due to notice given to the employer after the 60-day notice period.

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

(Employer must check one prior to giving to the applicant/qualified beneficiary.)

- You are NOT eligible for continuation coverage. Please refer to Item 1 of the attached notice.  
 You are eligible for continuation coverage. Please read instructions below.

## INSTRUCTIONS

**Your health insurance coverage will end on the date indicated in Item 2 of the attached notice, unless the Department of Employee Trust Funds (ETF) receives the attached notice postmarked within 60-days of the date of the employer's signature in Item 8 or within 60 days of the date your coverage ends (Item 2), whichever is later.**

### A CONTINUATION

Coverage under the group health insurance program will end for you and all other qualified beneficiaries (QBs) on the date entered in Item 2 of the attached notice. A QB is a person losing coverage who was covered on the date of the qualifying event entered in Item 4 of the attached notice. Under Federal Law, known as COBRA, you may continue this coverage. Continuation provides the same coverage you currently have in force and is available, in most cases, for 36 months from the date of occurrence in Item 4. At the end of the 36-month period, you may convert to a non-group policy.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal Law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you have the right under Federal Law to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

You may elect a different health plan at the time continuation is elected if you reside in a county that does not include primary providers in the subscriber's health plan. You may change health plans if you move out of the county, if your health plan ceases to be offered, or during the annual Dual-Choice Enrollment period. Please continue to reference your annual *It's Your Choice* book for additional information concerning your health insurance coverage.

Continuation coverage for you and all other QBs will cease and cannot be reinstated on the earliest of the following: 1) the date coverage ceases because premium is not paid timely; 2) the date your former employer no longer offers any group health coverage; 3) the date you and/or any covered QB become covered under another group health plan after the qualifying event on this application. (Note: If the replacement group health plan has a pre-existing conditions limitation, you remain eligible for our continuation coverage, but only until the creditable coverage to which you are entitled satisfies the pre-existing condition limitations of your replacement coverage.)

The employee or the employee's spouse can elect continuation coverage on behalf of all of the QBs. A parent may elect to continue coverage on behalf of any dependent children. Each QB affected by this notice (i.e., who is losing coverage) has an independent right to elect coverage. Contact the employer entered on Item 8 of the notice for information about enrolling for individual coverage(s).

**The employer must be notified of loss of coverage within 60 days of the event or your right to continue group coverage is lost, except in the case of divorce.**

To elect continuation coverage:

1. Check box A on the attached *Continuation-Conversion Notice*; date and sign the notice.

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

**CONTINUATION – CONVERSION NOTICE**  
 Group Health Insurance  
 s. 2201 of Public Law 99-272

Employee Social Security Number <u>123-45-6789</u>	
Employee Name (Last, First) <u>Smith, Jonathon</u>	
Employee's Birthdate: (MM/DD/CCYY) <u>01/01/1960</u>	Group # <u>84999</u>

Applicant/Qualified Beneficiary Information:\* (To be completed by the Employer)

123 Apple St  
 Street and No.  
Anytown WI 59876  
 City State Zip Code

Employee  
 Spouse/Former Spouse Name \_\_\_\_\_  
 Dependent Child(ren) Name(s) Susie Smith

\*Applicant must also complete ET-2301 or ET-2302 if electing to continue or convert coverage, unless applicant is the Employee and will be continuing the coverage in effect.

**TO BE COMPLETED BY APPLICANT**

Complete and return this notice ONLY if electing to continue or convert coverage.

**APPLICANT:** Read the instructions on the front before completing this notice. It contains important eligibility and other information concerning your rights and responsibilities. If you wish to continue your coverage, the Department of Employee Trust Funds must receive this notice postmarked within 60 days after your coverage ends or within 60 days of the date shown in Item 8 below, whichever is later.

**CHECK ONE ONLY** - Box A, B, C, or D. See the instructions for information which corresponds to the following elections.

- A  I elect to continue coverage under the group health plan for a maximum of 36 months. I understand the health plan will bill me directly for premiums at the above address. OR
- B  I elect to convert the group coverage to a non-group policy. (Conversion may be considerably more expensive and/or provide fewer benefits.) if electing this option, I understand I am subject to the health plan's conversion policy provisions. OR
- C  I have 20 years of creditable service and I am eligible to apply for an immediate annuity but am not applying at this time and want to continue my insurance. OR
- D  (For State participants only) I have 20 years of creditable service, and am terminating state employment. (If electing this option, the Department of Employee Trust Funds must receive this completed notice by the date shown in Item 2. below.)

**DIFFERENT COUNTY:**  I have elected coverage and I live in a county that does not have a primary physician in the current health plan. I have indicated on the application form (ET-2301 or ET-2302) the health plan to which I am switching.

**MEDICARE:**  Check here if you or anyone on your policy is eligible for Medicare Parts A & B. (See instructions.)

Date (MM/DD/CCYY)	Signature of Applicant	Daytime Telephone ( )
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**TO BE COMPLETED BY EMPLOYER PRIOR TO GIVING TO THE APPLICANT**

**EMPLOYER:** Federal law requires this notice to be issued to qualified beneficiaries within 14 days after the date in Item 5. Complete the information above and Items 1-8 below. Refer to the *Group Health Insurance Employer Administration Manual* for further assistance.

1. Not eligible: (Reason) Notice to employer given after 60-day notice period.

2. Date applicant/qualified beneficiary's coverage ends: 7/31/06

3. Reason for coverage ending (the qualifying event): (check one)  
 Employment terminated  Death  
 Divorce entered  Dependent no longer eligible (reason) married  
 Other \_\_\_\_\_

4. Date of occurrence in Item 3: 7/17/2006

5. Date employer notified of occurrence in Item 3: 12/20/2006

6. Coverage in effect at time of occurrence in Item 3:  Single  Family

7. Name of Health Plan Dean Health Plan Monthly Premium Rate: \$ 1090.60

8. Completed By Betty Lou Payroll Date Notice Provided (MM/DD/CCYY) 12/22/2006 Employer Name State Agency ABC Telephone (608) 123-1444  
123 Any St, MADISON WI

**FOR EMPLOYEE TRUST FUNDS USE**

New Group Number	Continued Coverage Effective From (MM/DD/CCYY) _____ Through (MM/DD/CCYY) _____	By _____	Date (MM/DD/CCYY)
		Telephone: <u>608-264-7900</u>	

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 7 — RETIREMENT, DISABILITY OR  
LONG-TERM DISABILITY INSURANCE**

- 701 Coverage – Requirements to Continue**
- 702 Coverage for Former State Employees Whose Coverage Has Lapsed**
- 703 Medicare Enrollment**
- 704 Premium Payment**

**701 Coverage – Requirements to Continue**

Coverage under the State Employee Group Health Insurance program may be continued when an employee is eligible for a retirement benefit or applies for a WRS disability or Long-Term Disability Insurance (LTDI) benefit upon termination of employment. In addition, subscribers and their insured dependents continuing coverage must enroll in Medicare Parts A and B when first eligible if they are not eligible at the time of retirement. (Refer to Subchapter 703.)

Note: Active employees (non-annuitants) reported on monthly remittance reports are not required to enroll in Medicare when first eligible and do not receive the Medicare reduced premium rate in the event they do enroll in Medicare.

- Retirement Benefit

Group health insurance coverage can be continued if the employee retires on an “immediate annuity.” An “immediate annuity” is defined as a benefit that begins within 30 days after the employee terminates employment. This benefit can be a monthly benefit or a lump sum annuity. (Also see Chapter 8 regarding Accumulated Sick Leave Conversion Credit program.)

Employees on an unpaid leave of absence immediately prior to retirement whose coverage lapsed due to non-payment of premiums can reinstate coverage if an immediate WRS annuity is taken and a health insurance application is filed with ETF within 30 days of notice that health insurance coverage can be reinstated.

- Disability or LTDI Benefit

Insured employees applying for a WRS disability or LTDI benefits must pre-pay premiums through their employers until their WRS disability or LTDI benefit is approved by ETF, or coverage will lapse. Employees on an unpaid leave of absence immediately prior to termination whose coverage lapses due to non-payment of premiums, can reinstate coverage if an immediate WRS disability or LTDI benefit is taken and a health insurance application is received by ETF within 30 days of the date of ETF’s letter offering coverage reinstatement. ETF will notify the employer when a disability or LTDI benefit is approved. The employer will then need to delete

the employee from active coverage. (Refer to Chapter 5.)

- Termination With 20 Years of WRS Service, Not Taking Immediate Annuity

Group coverage can be continued when terminating after age 55 (50 for protective category employees) and the employee has at least 20 years of creditable WRS service, even if an immediate retirement annuity is not taken. The employee completes and submits, to ETF, a *Continuation – Conversion Notice* (ET-2311) at the time of the employee's termination. (Refer to Subchapter 608 for instructions regarding this form.)

- Termination Before Minimum Retirement Age With 20 Years of Service

Insured State employees leaving State service before reaching minimum retirement age (therefore, not eligible for an immediate annuity) with at least 20 years of creditable WRS service who do not close their WRS account, may continue coverage under the State group plan indefinitely. These employees are required to pay the full premiums. They cannot use sick leave credits to pay premiums or apply to escrow their sick leave credits until they later apply for their retirement annuity. They must complete a *Continuation-Conversion Notice* and a *Group Health Insurance Application* (ET-2301).

For additional information, see *Group Health Insurance for Retired State Employees, State Employees with 20 Years of Service Who Terminate Employment, and Surviving Spouses and Dependents of Insured Employees* (ET-4112).

## **702 Coverage for Former State Employees Whose Coverage Has Lapsed**

Former State employees whose coverage has lapsed may be eligible to apply for coverage under the State Employee Group Health Insurance program if they meet one of the following conditions:

- Receiving a monthly annuity or received a lump sum from the WRS.
- Terminated State employment before reaching their minimum retirement age of 55 (50 for protective category employees) with at least 20 years of creditable service.

For additional information, see *Group Health Insurance for Retired State Employees, State Employees with 20 Years of Service Who Terminate Employment, and Surviving Spouses and Dependents of Insured Employees* (ET-4112).

## **703 Medicare Enrollment**

Annuitants and insured dependents eligible for coverage under the Federal Medicare program must enroll in Parts A and B when first eligible due to age or disability per Wis. Stats. § 40.51(7) and 40.52(2). Annuitants and insured dependents failing to enroll in Medicare will be held responsible for the portion of claims that Medicare would have covered, had they been enrolled in Medicare, and must enroll in Medicare at the next available opportunity.

A *Medicare Eligibility Statement* (ET-4307) and a copy of the Medicare card is used to inform ETF of the Medicare effective dates. ETF will mail the *Medicare Eligibility Statement* to the retiree for completion. A sample of the *Medicare Eligibility Statement* appears at the end of this subchapter. Please provide ETF with a copy of the retiree's Medicare card, when available.

**Medicare Eligibility Statement (ET-4307)**

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

**MEDICARE ELIGIBILITY STATEMENT**

Wis. Stat. §§ 40.51 (7) and 40.52 (2)

*Return form to the Department of Employee Trust Funds.*

SUBSCRIBER NAME – <i>Policy Holder</i> (Last, First, Middle, Maiden)		SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	Social Security Number
ADDRESS (Street, City, State, Zip Code)			Insurance Plan Name
			Group Number

**TO CONTINUE COVERAGE THIS FORM MUST BE FILLED OUT COMPLETELY**

- In order to continue to be insured under the group health insurance program, you and/or your insured family members must be enrolled for both portions of Medicare (Hospital Part A and Medical Part B), when Medicare is first available as the primary insurer. Contact the Social Security Administration for information on how to enroll.  
Exception: You and your dependents are not required to be enrolled in Medicare until the subscriber terminates employment or health insurance coverage as an active employee ceases.  
You must inform ETF immediately if you or your spouse's Medicare Part B is dropped for any reason.

- Indicate the reason Medicare is available:
  - a. Attainment of age 65 and over.
  - b. Receipt of Social Security disability payments for 24 months.
  - c. Permanent kidney failure.

- List below all persons insured under your group health insurance policy. List Medicare effective dates as they appear on each person's Medicare I.D. card OR contact the Social Security Administration for effective dates. If not eligible for MEDICARE, enter "NOT ELIG." in Effective Dates columns.
- Attach a photocopy of your Medicare Health Insurance Card or documentation from Medicare clearly stating your Medicare claim numbers and effective dates.

HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY JOHN Q PUBLIC	
CLAIM NUMBER 000-00-0000-0	SEX MALE
IS ENTITLED TO HOSPITAL MEDICAL	EFFECTIVE DATE
(PART A)	00-00-00
(PART B)	00-00-00
SIGN HERE →	<i>John Q Public</i>

NAMES	Birthdate (MM/DD/CCYY)	Claim Number	MEDICARE EFFECTIVE DATES as shown on card	
			Hospital (PART A)	Medical (PART B)
Subscriber				
Spouse				
Dependents				

Those who fail to enroll in federal MEDICARE must attach a written explanation to this form.

I authorize the Department of Employee Trust Funds to verify information from the Social Security Administration, if need be, regarding eligibility for effective dates of coverage under both Medicare Parts "A" and "B."

Date (MM/DD/CCYY)	Signature	Daytime Telephone Number
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**FOR ETF USE**

Enrollment Type	Employee Type	Coverage Code	Carrier Suffix	Payroll Representative Signature	Telephone
Name of Employer				Employer Number 69-036-	Group Number

## 704 Premium Payments

Annuitant premium payments are made through one of the following methods:

- A. Sick leave credits—From sick leave credits until exhausted, Wis. Stats. § 40.05(4)(b). Sick leave credits may be escrowed up to ten years at the time of retirement if the employee is covered under comparable non-state health coverage. The employee should contact ETF for information and a *Sick Leave Escrow Application* (ET-4305);
- B. Annuity Deduction—Premiums are paid from a monthly retirement or disability annuity if the annuity is sufficient to cover the entire premium;
- C. Direct Pay—When the annuity is not sufficient to cover the entire premium, the health plan will directly bill the annuitant and the annuitant will pay premiums directly to the health plan.
- D. Group Life Insurance Conversion—This program, governed by Wis. Stat. § 40.72(4r) and Wis. Admin. Code § ETF 60.60, allows eligible employees to convert their group life insurance to pay health insurance premiums. For more information, see the *Converting Your Group Life Insurance to Pay Health or Long-Term Care Insurance Premiums* brochure (ET-2325).

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 8 — ACCUMULATED SICK LEAVE CONVERSION CREDITS**

<b>801</b>	<b>Accumulated Sick Leave Conversion Credit Program</b>
<b>802</b>	<b>Eligibility</b>
<b>803</b>	<b>Unpaid Leave</b>
<b>804</b>	<b>Permanent Layoff</b>
<b>805</b>	<b>Permanent Layoff Sick Leave Conversion Reference Chart</b>
<b>806</b>	<b>Accumulated Sick Leave and Chapter 40 Terminations</b>
<b>807</b>	<b>Completing <i>Accumulated Leave Certification</i> (ET-4306)</b>
<b>808</b>	<b>Sample <i>Accumulated Leave Certification</i> (ET-4306)</b>
<b>809</b>	<b>Escrow of Sick Leave Credits</b>
<b>810</b>	<b>Payment</b>
<b>811</b>	<b>Annual Statement of Account</b>

**801 Accumulated Sick Leave Conversion Credit Program**

In accordance with Wis. Stat. Ch. 40, eligible employees can convert accumulated sick leave hours to a dollar-based credit to pay premiums for coverage under the State Employee Group Health Insurance program (if an applicable compensation plan or collective bargaining agreement provides for sick leave conversion). Accumulated sick leave is converted to credits only for the payment of State group health insurance premiums. The sick leave credits are computed as follows:

HOURS x HIGHEST BASIC PAY RATE = SICK LEAVE CREDITS

**802 Eligibility**

The following participants are eligible:

- Terminated, Insured Employee (enrolled in State Employee Health Insurance program at time of termination) - ETF will determine if the employee is eligible for use of sick leave credits.

Sick leave credits can be used to pay health insurance premiums if one of the following eligibility requirements is met:

1. Retirement with an immediate annuity (an immediate annuity is a monthly benefit or retirement lump sum benefit that has an effective date within 30 days of termination); or
2. Terminate employment at age 55 (50 for protective category employees) and have 20 years of creditable WRS service; or

3. Qualify for a WRS 40.65 duty or 40.63 regular disability benefit or Long-Term Disability Insurance (LTDI).

**The employer must submit an *Accumulated Leave Certification (ET-4306)* to ETF.**

- Surviving Insured Spouse or Dependents - Within 90 days of the employee's death, the **surviving insured spouse and insured dependents must submit a *Health Insurance Application (ET-2301)* to ETF and the employer must submit an *Accumulated Leave Certification* to ETF.** (See Chapter 10 - Employee Death.)
- Public Official: Delayed Use of Sick Leave Credits – The following participants can retain accumulated unused sick leave for the purpose of converting the sick leave, at the time of application for retirement benefits, to credits for the payment of post-retirement health insurance premiums under the State Employee Group Health Insurance program:
  - State constitutional officers
  - Members or officers of the Legislature
  - State agency heads appointed by the Governor with Senate confirmation
  - Heads of a legislative service agencies
  - Certain State administrative officials
  - Employees with 20 years of WRS creditable service terminating before their retirement age (providing the do not elect a WRS separation benefit).

**To ensure an accurate record, the employer must submit an *Accumulated Leave Certification* to ETF at the time of termination of WRS employment in the covered position.** Indicate on the top of the certification - PUBLIC OFFICIAL DELAYED SICK LEAVE USE. The final hourly salary is the employee's basic pay rate of his or her position at the time that the employee terminated that position.

- Employee on Unpaid Leave (See Subchapter 803.)
- Employee on Permanent Layoff (See Subchapter 804.)

### 803 Unpaid Leave

Employees on unpaid leave or temporary layoff are eligible to continue coverage and the following chart outlines the provisions for continued coverage:

How Long is Coverage Available	Payment of Premiums	Employee-Required Contributions	Employer-Required Contributions
An additional 3 months of employer contribution toward premium. Thereafter, employee may continue: 1) Up to five years using converted sick leave	Paid in advance by deduction from last payroll check or by personal	After 3 additional months of employer premium upon layoff, employee is responsible for all employer and	First 3 months (in addition to any prepaid months at time of termination) after employee is laid off.

<p>to pay premiums until the sick leave credits are exhausted; 2) Followed by 36 months under COBRA continuation provisions, by paying full premium after the employer contribution ends or after sick leave credits are exhausted, or 3) For life if employee has 20 years of creditable service, with premiums paid by the employee or from sick leave conversion credits if the employee begins or is eligible for an immediate WRS annuity.</p>	<p>check; then 30 days prior to the end of the period for which premiums were previously paid. Any employee share must be paid in advance by deduction from the employee's last check or by personal check if not using sick leave credits.</p>	<p>employee contributions. During temporary layoff only, accumulated unused sick leave may be converted, by the employer, to a dollar amount to pay premiums . Premiums are deducted until: 1) the sick leave credits are exhausted, 2) the 1<sup>st</sup> of the month following the employee's acceptance of other employment offering a comparable health insurance plan or policy, or 3) five years have elapsed from the date of layoff, whichever occurs first.</p>	
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### 804 Permanent Layoff

For group health insurance purposes, a State employee whose employment is terminated due to permanent layoff is to be treated as if terminated for retirement purposes or on a leave of absence per §40.02(40) and §40.05(4)(bm), Wis. Stat., meaning that upon termination due to permanent layoff, health insurance coverage may be continued. In addition, all employees terminated due to permanent layoff are entitled to an additional 3 months of State contribution toward the health insurance premium. This is in addition to the premiums that have already been remitted in advance through normal payroll deduction.

#### A. Conversion of Accumulated Sick Leave (§40.05(4)(b), Wis. Stat.)

This provision applies to a State employee terminated due to permanent layoff (or a State employee otherwise terminated, e.g., for retirement purposes) who:

1. begins an immediate annuity; or
2. receives a lump sum annuity; or
3. has 20 years of creditable service and **is eligible** to retire on an immediate annuity, but delays application.

These state employees are eligible to convert accumulated sick leave under the provisions of the Accumulated Sick Leave Conversion Credit Program (ASLCC) and Supplemental Health Insurance Conversion Credit Program (SHICC) programs as

follows:

- Accumulated unused sick leave is converted at the employee's **highest basic rate of pay** while employed by the state (the SHICC conversion rate is dependent upon the employee's contractual status with the state, as noted above). Upon receipt of the employer's certification of the converted sick leave, ETF will convert the amount to sick leave credits for payment of health insurance premiums. Accumulated and Supplemental sick leave is converted and certified by using the *Accumulated Leave Certification* (ET-4306).
- Sick leave may be used to fund the employee's premium contribution effective the first of the month following the date the layoff begins, if there is an employee contribution due, for the three additional months of employer paid premium as provided in §40.05(4)(a)3, Wis. Stat. After the three additional months of state contribution toward premium, the full amount of the premium will be deducted by ETF from the sick leave credits until the credits are exhausted.
- Under §40.05(4)(b), Wis. Stat., the employee may elect to delay using converted sick leave credits if the employee is covered under a comparable health insurance plan. Comparable health insurance means a plan or policy that provides hospital and medical benefits substantially equivalent to those of the standard health insurance plan established under §40.52(1), Wis. Stat.

B. Conversion of Accumulated Sick Leave §40.05(4)(bc), Wis. Stat.

This provision applies to a state employee terminated due to permanent layoff (or a State employee otherwise terminated, e.g., for retirement purposes) who:

1. has attained 20 years of creditable service,
2. remains a participant (does not take a separation benefit from the WRS), and
3. **is not eligible** for an immediate annuity (i.e., is not age 55 [age 50 for protective occupations]).

Once eligible to apply for a retirement annuity or lump sum retirement annuity, these state employees are eligible to convert accumulated sick leave under the provisions of the ASLCC program and if eligible, the SHICC program, effective the date on which the department receives the employee's retirement application as follows:

- Accumulated unused sick leave is converted at the employee's highest basic rate of pay while employed by the state (the SHICC conversion rate, if applicable, is dependent upon the employee's contractual status with the state, as noted above). Upon receipt of the employee's retirement application, ETF will convert the amount to sick leave credits for payment of health insurance premiums. Accumulated and Supplemental sick leave is converted by use of the *Accumulated Leave Certification*, certified by the employer upon the employee's termination.
- At the request of the employee, the employer must convert accumulated sick leave to fund the employee's premium contribution, if any, effective the first of the month following the date the layoff begins under the provisions of §40.05(4)(a)3,

Wis. Stat. After the three additional months of state contribution toward premium, the employer will certify the remaining unused sick leave balance to ETF, unless the employee requests the employer continue converting accumulated sick leave under §40.05(4)(bm) [see below]. In this situation, the employer would then certify any remaining unused sick leave balance using the *Accumulated Leave Certification*.

- An employee covered under a comparable health plan with sick leave preserved under §40.05(4)(bc), Wis. Stat., may elect—at the time they are eligible for an annuity and submit a retirement application—to delay using the converted sick leave credits per §40.05(4)(b), Wis. Stat. (Comparable health insurance means a plan or policy that provides hospital and medical benefits that are substantially equivalent to the standard health insurance plan established under §40.52(1), Wis. Stat.)

C. Conversion of Accumulated Sick Leave §40.05(4)(bm), Wis. Stat.

**Note:** An *Accumulated Leave Certification* is **not** completed or submitted to ETF for employees only eligible for sick leave conversion under §40.05(4)(bm), Wis. Stat. (i.e., termination due to layoff). The use of sick leave conversion under §40.05(4)(bm), Wis. Stat., during layoff is the record keeping and funding responsibility of the employing agency. The employee premium is to be remitted to ETF in the same manner as other active employees participating in the group health insurance program.

This provision applies to a state employee terminated due to permanent layoff, including those who are:

1. not eligible for an immediate annuity; or
2. eligible to begin an immediate annuity with less than 20 years creditable service, but defers application.

These employees may, on request to the employer, have the employer convert their accumulated sick leave for the purpose of paying health insurance premiums, as detailed below.

**It is the employer's responsibility to notify employees subject to permanent layoff of the following provisions:**

- Upon request between the date on which the employee receives notice of layoff and the actual layoff date, accumulated unused sick leave may be converted by the employing agency at the employee's highest basic rate of pay while employed by the state, for payment of health insurance premiums.
- Sick leave may be used to fund the employee's premium contribution effective the first of the month following the date the layoff begins. After the three additional months of state contribution toward premium, the employee is responsible for the full employee and employer premium, although sick leave credits may be converted by the employer to pay the entire cost.
- An employee using sick leave credits under this provision that returns to state

employment and is eligible for reinstatement, will have any unused sick leave hours reinstated.

- The full amount of the required premium shall be deducted from the credits until the first of the following occurs:
  1. The credits are exhausted;
  2. The employee accepts other employment with a comparable health insurance policy or plan (even if the employee declines the coverage). This coverage ends the first of the month following the date of other employment; or
  3. Five years elapse from the layoff date.

Health insurance continuation coverage (in compliance with COBRA) using the *Continuation - Conversion Notice* (ET-2311) must be offered when the available sick leave premium contribution ends. (See Chapter 6.)

### 805 Permanent Layoff Sick Leave Conversion Reference Chart

This chart provides information regarding sick leave conversion at the time of an employee's permanent layoff (based upon employee status at the time of termination).

<b>Employee status at time of permanent layoff.</b>	<b>Statutory Reference</b>	<b>State Health Contribution</b>	<b>ASLCC Program</b>	<b>SHICC Program</b>	<b>Administrative Responsibility</b>
1. Begins immediate annuity or annuity lump sum. [§40.25 (1)]	§40.05(4)(a)3 §40.05(4)(b)	<ul style="list-style-type: none"> <li>• Up to 2 months prepaid plus additional 3 months.</li> </ul>	Sick leave converted and used once the employer's obligation under §40.05(4)(a) 3 has been met unless escrowed according to 40.05(4)(b).	Available after ASLCC is exhausted if the employee has 15 years adjusted continuous state service. Other OSER regulations apply.	<ul style="list-style-type: none"> <li>• Employing agency pays premiums for 3 months after layoff (not including pre-paid months) as though an active employee.</li> <li>• Employing agency submits <i>Accumulated Leave Certification</i> (ET-4306) to ETF. ETF deducts full amount of premium until sick leave credits are exhausted.</li> </ul>

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<b><i>Employee status at time of permanent layoff.</i></b>	<b><i>Statutory Reference</i></b>	<b><i>State Health Contribution</i></b>	<b><i>ASLCC Program</i></b>	<b><i>SHICC Program</i></b>	<b><i>Administrative Responsibility</i></b>
2. Eligible for immediate annuity with less than 20 years of creditable service, but defers application.	§40.05(4)(a)3  §40.05(4)(bm)	<ul style="list-style-type: none"> <li>Up to 2 months prepaid plus additional 3 months.</li> <li>If requested, employing agency converts sick leave for health insurance until the first of: credits being exhausted; 1<sup>st</sup> of month following employee's acceptance of other employment with a comparable health insurance plan or policy; or 5 years have elapsed.</li> </ul>	Ineligible – any remaining sick leave after §40.05(4)(bm) use is lost unless employee reinstates into State service within 5 years.	Ineligible	<ul style="list-style-type: none"> <li>Employing agency pays premiums for 3 months after layoff as though an active employee.</li> <li>Employing agency converts sick leave and submits health insurance premiums to ETF as though employee is active employee. Employing agency responsible for administration, funding and monitoring sick leave balance.</li> </ul>
3. Eligible for immediate annuity with 20 or more years of creditable service, but defers application.	§40.05(4)(a)3  §40.05(4)(b)	<ul style="list-style-type: none"> <li>Up to 2 months prepaid plus additional 3 months.</li> </ul>	Sick leave converted and used once the employer's obligation under §40.05(4)(a)3 has been met unless escrowed according to 40.05(4)(b)	Available after ASLCC is exhausted if the employee has 15 years adjusted continuous state service. Other OSER regulations apply.	<ul style="list-style-type: none"> <li>Employing agency pays premiums for 3 months after layoff (not including prepaid months) as though an active employee.</li> <li>Employing agency submits <i>Accumulated Leave Certification</i> to ETF. ETF deducts full amount of</li> </ul>

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<b>Employee status at time of permanent layoff.</b>	<b>Statutory Reference</b>	<b>State Health Contribution</b>	<b>ASLCC Program</b>	<b>SHICC Program</b>	<b>Administrative Responsibility</b>
					premium until sick leave credits are exhausted.
4. Not eligible for immediate annuity with less than 20 years of creditable service.	§40.05(4)(a)3  §40.05(4)(bm)	<ul style="list-style-type: none"> <li>Up to 2 months prepaid plus additional 3 months.</li> <li>If requested, employing agency converts sick leave for health insurance until the first of: credits being exhausted; 1<sup>st</sup> of month following employee's acceptance of other employment with a comparable health insurance plan or policy; or 5 years have elapsed.</li> </ul>	Ineligible – any remaining sick leave after §40.05(4)(b m) use is lost unless employee reinstates into State service within 5 years.	Ineligible	<ul style="list-style-type: none"> <li>Employing agency pays premiums for 3 months after layoff (not including prepaid months) as though an active employee.</li> <li>Employing agency converts sick leave and submits health insurance premiums to ETF as though employee is active employee. Employing agency responsible for administration, funding and monitoring sick leave balances.</li> </ul>
5. Ineligible for an immediate annuity with 20 or more years of creditable service.	§40.05(4)(a)3  §40.05(4)(bm)  §40.05(4)(bc)	<ul style="list-style-type: none"> <li>Up to 2 months prepaid plus additional 3 months.</li> <li>If requested, employing agency converts sick leave for health insurance until the first of: credits being</li> </ul>	Sick leave converted by employer to meet employer's obligation under §40.05(4)(b m). Remaining sick leave balance is certified to	Available after ASLCC is exhausted if the employee has 15 years adjusted continuous state service. Other	<ul style="list-style-type: none"> <li>Employing agency pays premiums for 3 months after layoff (not including prepaid months) and converts unused sick leave to pay any employer share of this</li> </ul>

<i>Employee status at time of permanent layoff.</i>	<i>Statutory Reference</i>	<i>State Health Contribution</i>	<i>ASLCC Program</i>	<i>SHICC Program</i>	<i>Administrative Responsibility</i>
		exhausted; 1 <sup>st</sup> of month following employee's acceptance of other employment with a comparable health insurance plan or policy; or 5 years elapsing.	ETF to be "preserved" for conversion at the time retirement application is submitted to ETF, unless it is escrowed according to 40.05(4)(b).	OSER regulations apply.	<p>premium. Employer reports employee to ETF as though an active employee, then,</p> <ul style="list-style-type: none"> <li>• Employing agency converts sick leave and submits health insurance premiums to ETF as though employee is active employee. Employing agency responsible for administration, funding and monitoring sick leave balance, and/or</li> <li>• Employing agency submits <i>Accumulated Leave Certification</i> for any remaining sick leave to be preserved by ETF for conversion upon receipt of retirement application.</li> </ul>

**806 Accumulated Sick Leave and Chapter 40 Terminations**

Effective April 1, 2006, an employee does NOT have to sever the employee/employer relationship to receive §40.63 Disability Retirement or LTDI benefits. Employers may

now elect to keep an employee on a LOA for purposes of maintaining fringe benefits not administered under Chapter 40, i.e., benefits provided by the employer but not administered by ETF. Employees terminated for Chapter 40 purposes but remaining on LOA for non-Chapter 40 benefit purposes are considered Chapter 40 terminations.

Sick leave balances with which the employee intends to pay for health insurance premiums are considered earnings not-paid. State employees must sever the employee/employer relationship if they wish to convert sick leave balances to pay for health insurance premiums. They cannot remain on a LOA as permitted with a Chapter 40 termination.

For more complete information on Chapter 40 terminations and accumulated sick leave, see *Employer Bulletin*, Vol. 23. No. 5, dated April 19, 2006.

### 807 **Completing *Accumulated Leave Certification* (ET-4306)**

An employer must submit an *Accumulated Leave Certification* (ET-4306) to ETF within 30 days after an employee's termination. Complete and submit the form for EACH employee terminating from State service:

- Who is age 55 or over (age 50 if protective occupation); or
- Who is applying for a disability benefit or LTDI; or
- Who died; or
- Who is a "PUBLIC OFFICIAL" (qualifies for delayed sick leave usage under 1991 WA 39 (Public Official)); or
- Who is terminating after 20 years of service but is not eligible for an immediate annuity (qualifies for delayed sick leave usage under 2003 WA 33).

INSTRUCTIONS - Type or print in ink. The *Accumulated Leave Certification* is available on-line at <http://etf.wi.gov/publications/employer.htm>. This form can be printed, completed manually, and mailed or faxed to DETF, or it can be completed on-line and sent as an e-mail attachment. Submit one copy to ETF and keep one copy for your records. A sample of the *Accumulated Leave Certification* appears in Subchapter 807.

- EMPLOYEE INFORMATION - Complete each item below:
  - a. Name - Enter as Last, First, Middle and Former.
  - b. Social Security Number - Enter nine-digit number.
  - c. Birthdate - Enter MM/DD/CCYY.
  - d. Address - Include street or P. O. Box No., City, State, and Zip Code.
  - e. Employment Category - Indicate non-teacher or teacher.
  - f. Gender - Indicate Male or Female.
  - g. Termination Date or Date of Death - Enter MM/DD/CCYY.
  - h. Reason for Termination - Indicate one and position title.

- i. Does employee have health insurance coverage? - Indicate "Yes" or "No".
- j. Is spouse employed by the State of Wisconsin? Indicate "Yes," "No," "Don't know," or "N/A."
- k. Is employee a dependent on spouse's State contract? - Indicate "Yes," "No," or "Don't Know." In the event the employee's spouse is employed by the State of Wisconsin, verify whether employee is a dependent on spouse's State contract.

Note: For employees without State health insurance coverage (neither their own coverage nor a dependent on the spouse's State contract), complete the Spouse Information and the Employer Information only and send form to ETF.

- Health Plan Information - Complete each item below:

Note: In the event the employee is a dependent on the spouse's State contract, provide the spouse's health carrier information.

- a. Health Plan - Enter the Name.
- b. Health Plan Code - Enter the two-digit suffix. Example: 01
- c. Coverage Type - Indicate Single or Family coverage.
- d. Group No. - Enter the five-digit number. Example: 83000

- Spouse/Dependent Information - Complete each item below:

Note: In the event the employee has family coverage, provide requested data for the covered spouse. For unmarried employees, provide data for the youngest dependent and indicate "dependent" on the form.

- a. Name - Enter as Last, First, Middle and Former of spouse/dependent.
- b. Social Security Number - Enter nine-digit number of spouse/dependent.
- c. Birthdate - Enter MM/DD/CCYY for spouse/dependent.

- Certification of Accumulated Sick Leave Complete each item below:

- a. Enter employee's unused sick leave hours; enter Ø if none. Convert minutes to a two-digit decimal.
- b. Enter other creditable leave hours.
- c. Enter total hours (a + b). Convert minutes to a two-digit decimal.
- d. Enter the employee's Highest Basic Pay Rate as a State Employee.
- e. Calculate and enter the "Amount Certified" (c x d).

- For Employer Use Only – Refer to OSER's *Wisconsin Human Resources Handbook*, Chapter 758 - "Administration of the Supplemental Health Insurance Conversion Credit (SHICC) Program" for regulations and examples regarding this program.
  - Enter the employee's seniority date.
  - Enter the employee's bargaining unit.
  - Years of service equal to or less than 24 - In the first box, enter the number of years of service equal to or less than 24. In the second box, enter the sum of that number multiplied by 52 hours (multiply the number by 78 for protective

category).

Example: Employee has 28 years of service. In the first box, enter 24. In the second, enter 1,248 (24 x 52).

- Years of service greater than 24 - In the first box, enter the number of years of service greater than 24. In the second box, enter the sum of that number multiplied by 104.

Example: Employee has 28 years of service. In the first box, enter 4. In the second, enter 416 (4 x 104.)

- f. Enter Supplemental Sick Leave hours (to include extra 500 hours if applicable). This is the total of the sums arrived at in “Employer Use Only” above plus 500 hours if applicable. See also OSER’s *Wisconsin Human Resources Handbook*, Chapter 758 - “Administration of the Supplemental Health Insurance Conversion Credit (SHICC) Program” for regulations and examples regarding this program.

Example: For the employee used above, enter 1,248 + 416. Also, add 500 hours to that number if applicable.

Note: The amount entered here may not exceed the actual number of sick leave credit hours an employee has accumulated at the time of the retirement, layoff, or death (Line a.) except where the addition of 500 hours (if applicable) causes the excess.

- g. Enter Highest Basic Pay Rate as State Employee. (See **NOTE** on form.)
- h. Calculate and enter the Amount certified (f x g).
- i. Enter a “Y” if the extra 500 hours are included.
- j. Total Amount Certified – Enter e + h.
- k. Enter the month and year through which premiums have been paid. This date should agree with the date being reported on the *Monthly Deletions Report* (ET-2612).

- Employer Information - Complete each item below:

- a. Group No – Enter the employer group number.
- b. Date – Enter the date (MM/DD/CCYY) the form is signed.
- c. Signature of Agent.
- d. Contact Name and Phone – Enter the name and phone number of person completing the form.
- e. Employer Name.

**808 Sample Accumulated Leave Certification (ET-4306)**

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

**ACCUMULATED LEAVE CERTIFICATION**

Wis. Stat. § 40.05 (4) (b) and Wis. Stat. § 40.02 (25) (b) and (bc)

Complete this form for each terminating employee who:

1. Is age 55 or over (age 50 if protective occupation); OR
2. Is applying for a disability benefit; OR
3. Died; OR
4. Qualifies for delayed sick leave usage under 1991 WA 39 (Public Official); OR
5. Qualifies for delayed sick leave usage under 2003 WA 33 (Employee terminating after 20 years service but not eligible for immediate annuity)

*THIS FORM MUST BE SUBMITTED WITHIN 30 DAYS AFTER TERMINATION. DO NOT SUBMIT BEFORE TERMINATION. TYPE OR PRINT IN INK.*

**EMPLOYEE INFORMATION**

Name (Last, First, Middle, Former)		Social Security Number	Birthdate (MM/DD/YY)
Address (Street or P.O. Box No., City, State, Zip Code)			Employment Category <input type="checkbox"/> Non-Teacher <input type="checkbox"/> Teacher
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Termination Date or Date of Death (MM/DD/YY) / /	Reason for Termination (see above) 1 <input type="checkbox"/> Retirement - Eligible    3 <input type="checkbox"/> Death    5 <input type="checkbox"/> WA 33 2 <input type="checkbox"/> Retirement-Disabled    4 <input type="checkbox"/> WA 39	
Does employee have state health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is spouse employed by State of Wisconsin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> N/A	Is employee a dependent on spouse's STATE contract? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	

**HEALTH PLAN INFORMATION** (Complete Spouse's health plan information if employee is a dependent on spouse's state contract)

Health Plan	Health Plan Code	Coverage Type <input type="checkbox"/> Single <input type="checkbox"/> Family	Group No.
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**SPOUSE/DEPENDENT INFORMATION**

Name (Last, First, Middle, Former)	Social Security Number	Birthdate (MM/DD/YY)
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**CERTIFICATION OF ACCUMULATED LEAVE**

a) Enter unused sick leave hours (enter Ø if none)	
b) Add other creditable leave hours (see instructions in Health Insurance Manual)	
c) Total Hours (a + b)	
d) Highest Basic Pay Rate as State Employee	\$
e) Amount Certified (c x d)	\$
<b>FOR EMPLOYER USE ONLY</b>	
Seniority Date:	Bargaining Unit:
Years of service equal to or less than 24	
Years of service greater than 24	
f) Enter Supplemental Sick Leave hours (include extra 500 hours if applicable)	
g) Highest Basic Pay Rate as State Employee*	\$
h) Amount certified (f x g)	\$
Enter a Y in the box if the extra 500 hours are included	
<b>TOTAL AMOUNT CERTIFIED (e + h)</b>	<b>\$</b>
Premiums have been paid for coverage through (MM/YY)	/ /

\* NOTE: In most cases the highest basic pay will be used, however there are some exceptions. Please refer to current bargaining agreements for represented employees. For some employees line g) will be calculated using the ending base pay rate, or, at the employee's request, the average of the employee's base pay rates during the three highest years. Contact the Office of State Employment Relations for clarification.

<b>EMPLOYER INFORMATION</b>			Group No.
Date (MM/DD/YY) / /	Signature of Agent	Contact Name and Phone	Employer Name

<b>FOR EMPLOYEE TRUST FUNDS USE ONLY</b>		
Effec. Date (MM/YY) /	Coverage Type	Premium Amount

Submit to ETF at above address.  
Keep a copy for your records.

### **809 Escrow of Sick Leave Credits**

Eligible state employees or their surviving dependents insured under the State Employee Group Health Insurance Program at the time of termination may elect to escrow the sick leave accumulated credits (i.e., delay initiation of sick leave conversion credits). The employee can elect to escrow the sick leave for an indefinite period if continuously covered by comparable, other non-state coverage. Comparable non-state health insurance coverage means a plan with hospital and medical benefits substantially equivalent to the state's Standard Plan.

If the employee is a dependent on a spouse's State group health insurance contract, the sick leave credits will automatically be placed in an inactive account until the spouse retires and depletes his or her own sick leave credits. Both spouses must meet the sick leave eligibility requirements.

The decision to escrow should be made upon termination of employment and may be renewed annually. The *Sick Leave Escrow Application* (ET-4305) form must be filed with ETF before the sick leave is converted and the deductions from the credits begin to pay health insurance premiums. State employees insured under the State Health Insurance Program can call ETF to request a *Sick Leave Escrow Application*. You can direct employees with questions on accumulated sick leave conversion credits and escrowing sick leave credits to the ETF Call Center toll-free number at (877) 533-5020 or (608) 266-3285 (local Madison)

### **810 Payment**

Payment for the use of Sick Leave Conversion Credits is secured from the Sick Leave Conversion Credit fund to which each participating employer contributes through the Wisconsin Retirement System monthly contribution report.

### **811 Annual Statement of Account**

Each January, ETF mails annuitants, survivors and dependents an annual statement giving the beginning balance and the current balance of his or her accumulated sick leave account.

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 9 — REHIRED ANNUITANTS**

- 901 Eligibility**
- 902 Coverage**
- 903 Disability Annuitants**

**901 Eligibility**

A Wisconsin Retirement System (WRS) annuitant's return to non-WRS covered employment following retirement does not affect their WRS annuity or health insurance benefits, if any. Eligibility under this chapter assumes the annuitant has met the requirements of a minimum break in service as explained in Chapter 15 of the *WRS Administration Manual* (ET-1127) and returns to a WRS covered position.

Under the provisions of Wis. Stat. § 40.26 (1), a WRS annuitant returning to WRS eligible employment may elect to terminate the annuity and return to active WRS participation by completing a *Rehired Annuitant Election* (ET-2319). The retirement annuity terminates effective the first of the month following ETF's receipt of the *Rehired Annuitant Election*. Rehired annuitants electing to return to active WRS participation are immediately eligible to apply for health insurance coverage through the active employer (any state agency, school district or local governmental employer that participates in the Wisconsin Public Employers Group Health Insurance program). Any remaining accumulated sick leave conversion credits are frozen until the employee subsequently retires again. Additional sick leave accrued from state employment after the employee elects to participate in the WRS is added to their existing sick leave balance when retiring again.

A rehired annuitant electing to return to active WRS participation is only eligible for health insurance coverage through the active employer; there is no option to continue the group health insurance coverage they held as a WRS annuitant. An annuitant rehired by a WRS participating employer not offering health insurance to its employees will lose group health insurance coverage as an annuitant by electing to participate in the WRS. In other words, regardless of whether an employer participates in the Group Health Insurance program or not, an annuitant electing to return to active WRS coverage is no longer eligible for annuitant health coverage. Eligibility for annuitant health insurance is retained only when a rehired annuitant elects not to return to active WRS participation.

**902 Coverage**

Upon receipt of the *Rehired Annuitant Election* (ET-2319), ETF will determine the WRS participation begin date and notify both the annuitant and the employer. For an employee who was insured as an annuitant, health insurance coverage through the active employer becomes effective the day after the coverage as an annuitant lapses. As premiums paid through the annuity are deducted two months in advance, insurance

is paid for two months beyond the annuity end date. Premiums paid through the annuitant's accumulated sick leave conversion account are also paid two months beyond the annuity end date. ETF will assist the employer in determining the date the rehired annuitant should be added to active coverage on the monthly additions report. A *Group Health Insurance Application* (ET-2301) electing coverage must be received by the employer within 30 days following the WRS participation begin date. When the employee retires again refer to Chapter 8 for instruction on continuation of their health insurance coverage, as the former annuitant is now considered an active employee.

A rehired annuitant electing to return to active WRS participation, but not electing to enroll in health insurance through the active employer ceases to be eligible for annuitant health coverage. However, ETF's continuation provisions allow an employee to continue coverage for a maximum of 36 months by paying the entire premium. ETF will notify the rehired annuitant of the right to continue prior coverage under COBRA law. Continuation coverage does not make the employee eligible to return to the prior annuitant group coverage when they again terminate employment and retire.

### **903 Disability Annuitants**

A participant receiving a disability annuity cannot actively participate in the WRS until the participant is no longer eligible for the disability annuity (i.e., the participant is medically certified as no longer disabled). However, a WRS re-employed disability annuitant who has not reached normal retirement age (65, or age 53-54 for protective category employees [53 for those with 25 or more years of creditable service; 54 for those with fewer than 25 years]) will have the disability annuity suspended if the individual earns more than a set "earnings limit" during a calendar year of employment. Eligibility for annuitant health and/or life insurance coverage continues during the period of annuity suspension.

A disability annuity will be terminated if it is determined that the re-employed disabled annuitant has recovered from their disability and is able to perform the duties of gainful occupation. Following termination of the disability annuity, annuitant health insurance coverage ceases and, if in a WRS eligible position, the employee is immediately eligible for health insurance offered by their employer.

ETF notifies both the employee and the employer of the WRS coverage begin date, defined as the first of the month after the disability termination date. Employers are notified of their obligation to provide the employee with a *Group Health Insurance Application* (ET-2301), *Life Insurance Application/Cancellation/Refusal* (ET-2304) and/or *Income Continuation Insurance Application* (ET-2307). ETF will coordinate between ending annuitant coverage and beginning active coverage if the rehired annuitant elects coverage. New applications must be filed with the employer within 30 days after the date the employee resumes active status under WRS.

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**CHAPTER 10 — EMPLOYEE DEATH**

**1001 Surviving Spouse and Dependents**

**1002 Surviving Spouse who is also an Employee Eligible for Coverage**

**1001 Surviving Spouse and Dependents**

In the event an employee or annuitant with family health coverage dies, the surviving spouse and/or eligible dependents may continue coverage at group rates without State contribution toward the premium. The surviving spouse may continue coverage indefinitely; dependent children (as defined under the program) may continue coverage as long as they remain eligible under the program.

Upon notification of the death of an employee or annuitant, the surviving spouse and dependents will be contacted directly by ETF about continuation rights and use of sick leave credits to pay health insurance premiums under this provision. Both surviving spouse and dependents have the option for continuation. In order for the insured spouse and dependent(s) of a deceased employee/annuitant to continue coverage, a *Group Health Insurance Application* (ET-2301) must be received by ETF within 90 days after the date of death or 30 days of the date ETF provides notice of the right to continue coverage as a survivor, whichever is later. Coverage will become effective the first of the month following the date of the employee or annuitant death. Premiums will be deducted from any WRS annuity the dependent may be receiving. If there is no annuity, or the annuity is insufficient to allow for the deduction of the premium, the survivor must pay the premium directly to the health plan.

Note: Survivors may not add persons to the policy who were not covered at the time of death, unless the individual was previously insured under the contract of the deceased employee and regains eligibility.

Should the surviving spouse (or annuitant) and dependent(s) not elect to continue coverage, coverage will end with the last day of the month for which premiums have been paid.

**The employer must promptly file an *Accumulated Leave Certification* (ET-4306) with ETF upon the death of an employee. (See Chapter 8.)**

**1002 Surviving Spouse who is also a State Employee Eligible for Coverage**

When an employee with family coverage dies, and the surviving spouse is also an eligible employee, the insured surviving spouse has three options:

- Enroll as the surviving spouse and retain coverage indefinitely as indicated in Subchapter 1001. Premiums will be paid through the WRS annuity or directly to the health plan.

- Enroll as an employee and receive the employer contribution share toward premium. In order to use the deceased employee's inactivated sick leave credits, the spouse must meet the eligibility requirements upon retirement as stated in Subchapter 701.
- Escrow the deceased spouse's sick leave credits and enroll as an employee (receive the employer contribution share toward premium). This allows the surviving spouse the right to lifetime coverage even if the spouse does not meet the retirement eligibility requirements.

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**CHAPTER 11 — CODES**

- 1101 County Codes**
- 1102 Coverage Codes**
- 1103 Employee Type Codes**
- 1104 Enrollment Type Codes**
- 1105 Standard Plan Waiting Period Codes**

The following codes are required for completing the employer sections of forms used in the administration of the State Agency Group Health Insurance program:

**1101 County Codes**

<b>Code</b>	<b>County</b>
01	Adams
02	Ashland
03	Barron
04	Bayfield
05	Brown
06	Buffalo
07	Burnett
08	Calumet
09	Chippewa
10	Clark
11	Columbia
12	Crawford
13	Dane
14	Dodge
15	Door
16	Douglas
17	Dunn
18	Eau Claire
19	Florence
20	Fond du Lac
21	Forest
22	Grant
23	Green
24	Green Lake
25	Iowa

<b>Code</b>	<b>County</b>
26	Iron
27	Jackson
28	Jefferson
29	Juneau
30	Kenosha
31	Kewaunee
32	La Crosse
33	LaFayette
34	Langlade
35	Lincoln
36	Manitowoc
37	Marathon
38	Marquette
39	Marquette
72	Menominee
40	Milwaukee
41	Monroe
42	Oconto
43	Oneida
44	Outagamie
45	Ozaukee
46	Pepin
47	Pierce
48	Polk

<b>Code</b>	<b>County</b>
49	Portage
50	Price
51	Racine
52	Richland
53	Rock
54	Rusk
55	St. Croix
56	Sauk
57	Sawyer
58	Shawano
59	Sheboygan
60	Taylor
61	Trempeleau
62	Vernon
63	Vilas
64	Walworth
65	Washburn
66	Washington
67	Waukesha
68	Waupaca
69	Waushara
70	Winnebago
71	Wood
99*	Other*

\* Used to indicate out-of-state location

### 1102 Coverage Codes

Code	Type of Coverage	Description
01	Single	Coverage is for the subscriber (employee) only.
02	Family	Coverage is for the subscriber (employee) and eligible dependent(s).
03	Graduate Assistants – Single	Coverage is for the subscriber Graduate Assistant (employee) only.
04	Graduate Assistants – Family	Coverage is for the subscriber Graduate Assistant (employee) and eligible dependent(s).
05	Medicare – Single	Single coverage for annuitant or continuant subscriber with Medicare.
06	Medicare – Family 1	Family coverage for annuitant or continuant subscriber; one person with Medicare.
07	Medicare – Family 2	Family coverage for annuitant or continuant subscriber, subscriber and dependent both with Medicare.

### 1103 Employee Type Codes

Code	Employee Type	Description
01	State-elected	Legislators, state constitutional officers, circuit, supreme court, or appeals judges, chief clerk or Sgt-at-Arms of the Senate or Assembly.
02	Regular State	State employee
03	UW Classified	UW other than faculty.
04	UW Unclassified	UW Faculty
05	WISCRAFT	For use by WISCRAFT only—for blind employees with over 1,000 hours.
07	Annuitant	Retired employee who is eligible for health insurance.
08	Surviving Spouse/ Dependent	Used for survivors of currently insured subscriber who dies while carrying family health insurance coverage.
10	Continuant	ETF Use Only - Continuant
11	Continuant – 1991 WA 152	Terminated State Employee with at least 20 years of creditable service.
12	Graduate Assistant	Graduate Assistants, employees in training, short-term academic staff, fellows and scholars (UW only; used on Health Insurance Application for grad assistants [ET-2302] and UW reports).
13	Continuant – Graduate Assistant	ETF Use Only - Graduate Assistant Continuant.

### 1104 Enrollment Type Codes

Code	Used For:	Enrollment Type	Description	Used On:
02	Additions	Initial Enrollment	Employee is applying for health insurance for the first time since becoming an eligible employee.	Application (ET-2301, ET-2302 or ET-2329) & Monthly Reports

Code	Used For:	Enrollment Type	Description	Used On:
03	Additions	Absent Without Earnings – LOA, Layoff, Appeal of Discharge	Eligible employee is/was on LOA or layoff during which time coverage lapsed or during an appeal of discharge.	Application & Monthly Reports
04	Additions	Transfer to another State Agency or employing group within the same Agency	Used for covered employee transferring from one State Agency to another State Agency or from one employing group with a State Agency to another within that same Agency.	Application & Monthly Reports
05	Additions	Terminated and Rehired Within 30 Days	Employee was terminated and rehired within 30 days.	Application & Monthly Reports
08	Additions	Missed Initial Enrollment Period	Employee did not apply for coverage during initial enrollment period. 180-day waiting period must be served for all pre-existing conditions for applicant and all listed dependents (including spouse). Can select Standard Plan option only.	Application & Monthly Reports
12	Additions	Deleted in Error	Listed to reinstate employee's coverage (with no lapse in coverage) which was previously deleted in error by the employer.	Monthly Reports
31	Additions	Spouse-to-Spouse Transfer	Insurance contract is being switched from one spouse to the other (both spouses being employed by the State).	Application & Monthly Reports
32	Additions	Returned From LOA or Layoff and Missed Dual-Choice	Employee let coverage lapse while on LOA or layoff, and was not on payroll during the entire Dual-Choice Enrollment period.	Application & Monthly Reports
33	Additions	Transfer To/From State Agency & Moves	Employee transfers between state agencies/divisions, and the transfer results in a move from one county to another	Application & Monthly Reports
39	Additions	Marriage where no coverage is in effect.	Special enrollment opportunity when employee is eligible though not enrolled.	Application and Monthly Reports
40	Additions	Dual-Choice	Employee changing plan only or plan and coverage during the annual Dual-Choice Enrollment period.	Application & Monthly Reports
41	Additions	Moved From Service Area	Employee relocates to a different county and is enrolling in a different plan.	Application & Monthly Reports
42	Additions	Birth, adoption or placement for adoption where no coverage is in effect.	Special enrollment opportunity when employee or dependent is eligible but not enrolled and there is a birth, adoption, or placement for adoption.	Application and Monthly Reports
48	Additions	Returned From Military LOA	Employee returned from Military LOA.	Application & Monthly Reports
49	Additions	Returned From Family Medical Leave of Absence (FMLA)	Employee returned from a FMLA.	Application & Monthly Reports

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<b>Code</b>	<b>Used For:</b>	<b>Enrollment Type</b>	<b>Description</b>	<b>Used On:</b>
51	Additions	Transfer to Standard Plan	ETF Use Only - Annuitant/continuant and/or spouse/dependent enrolled in Medicare, subscriber and all dependents. Coverage is under Medicare +\$1,000,000. .	Application & Monthly Reports
52	Additions	Annuitant – Transfer between Premium Payment Groups	ETF Use Only - Movement between Sick Leave, Annuity deductions, and direct billing groups.	Application & Monthly Reports
53	Additions	Annuitant	Transfer from active employer group to annuitant group.	Application & Monthly Reports
54	Additions	Return from LOA to Annuitant Group	Employee on leave of absence who terminates and is now an annuitant who wants to re-enroll in health insurance.	Application & Monthly Reports
55	Additions	Continuation to Spouse/ Dependent as a Result of Death	Continuation as survivors to insured spouse/dependent because of death of the subscriber.	Application & Monthly Reports
57	Additions	Re-enrollment from Escrow	State employee, spouse and dependent(s) only, activating sick leave credits and re-enrolling in State Group Health Insurance program	Application & Monthly Reports
58	Additions	Suspension Annuity	ETF Use Only - Health insurance premium not collected due to temporary suspension of annuity payments. .	Application & Monthly Reports
59	Additions	1991 Wis Act 113	State employee only, retiree applied with evidence of insurability	Application & Monthly Reports
62	Additions	Continuation to Spouse/ Dependent As a Result of Death	Continuation as survivors to insured spouse/dependent because of death of the subscriber who was on a Disability Benefit.	Application & Monthly Reports
63	Additions	Continuation from active coverage to coverage as a continuant.	ETF Use Only – Active employee or eligible spouse/dependent who loses eligibility for existing active coverage and elects to continue coverage as a continuant.	Application & Monthly Reports
67	Additions	Loss of Coverage	An employee’s initial application for coverage within the Group Health Insurance program which is being submitted beyond the employee’s initial enrollment periods due to special enrollment opportunity.	Application & Monthly Reports
03	Deletions	Absent Without Earnings – LOA, Layoff, Appeal of Discharge	Eligible employee is/was on LOA, layoff or an appeal of discharge during which time coverage lapsed.	Application & Monthly Reports
04	Deletions	Transfer to another State Agency or employing group within the same Agency	Used for covered employee transferring from one State Agency to another State Agency or from one employing group with a State Agency to another within that same Agency.	Monthly Reports
09	Deletions	Cancellation	Currently insured subscriber voluntarily cancels coverage, but is not terminating employment.	Application & Monthly Reports
10	Deletions	Termination	Currently insured subscriber who terminates employment with the current employer group.	Monthly Reports

Code	Used For:	Enrollment Type	Description	Used On:
11	Deletions	Death	Currently insured employee, annuitant or continuant dies.	Monthly Reports
31	Deletions	Spouse-to-Spouse Transfer	Insurance contract is being switched from one spouse to the other (both spouses being employed by the same employer).	Monthly Reports
33	Deletions	Transfer To/From State Agency & Moves	Employee transfers between state agencies/divisions, and the transfer results in a move from one county to another.	Monthly Reports
40	Deletions	Dual-Choice	Employee changing plan and coverage or plan only during the annual Dual-Choice Enrollment period.	Monthly Reports
41	Deletions	Moved From Service Area	Employee relocates out of their current health plan's service area and is enrolling in a different plan.	Monthly Reports
50	Deletions	Retires	Employee retires.	Monthly Reports
51	Deletions	Transfer to Standard Plan		Application & Monthly Reports
52	Deletions	Annuitant – Transfer between Premium Payment Groups	Movement between Sick Leave, Annuity deductions, and direct billing groups.	Monthly Reports
56	Deletions	Escrow /Suspension	State employee, spouse and dependents(s) only, electing to escrow sick leave credits (voluntary cancellation of their coverage). DO NOT OFFER CONTINUATION. Please note: Eligible for coverage by reactivating sick leave account at later date	Application & Monthly Reports
64	Deletions	Loss of Continuation Status	ETF Use Only - Continuation coverage ends due to lack of premium payment, or becomes eligible for coverage through another Group Health Insurance program.	Monthly Reports
43	Changes	Changes From Single to Family Coverage	Employee changes from single coverage to family coverage.	Application & Monthly Reports
44	Changes	Changes From Family Coverage to Single Coverage (only dependent no longer eligible)	Employee changes to single coverage because there are no longer any eligible dependents.	Application & Monthly Reports
45	Changes	Change From Family Coverage to Single Coverage (at least one dependent still eligible)	Employee has eligible dependents, but voluntarily elects to change to single coverage.	Application & Monthly Reports
46	Changes	Coverage Type Change – Medicare	ETF Use Only - Annuitant or continuant coverage level is changing to a Medicare coverage level.	Application & Monthly Reports

Code	Used For:	Enrollment Type	Description	Used On:
47	Changes	Birth, adoption or placement for adoption and single coverage is in effect.	Changing from single to family coverage due to birth, adoption or placement for adoption.	Application & Monthly Reports
68	Changes	Change in Level of Coverage	Change in the level of coverage (single coverage to family) due to special enrollment opportunity where any dependent loses coverage under a separate plan.	Application & Monthly Reports
07	Other	Declined	Employee declines to enroll for health insurance when first eligible for coverage. Employee must submit a signed application indicating that they are declining coverage.	Application
65	Other	Information Change Only	The employee's level of coverage remains the same as well as the health plan; however, an indicative data change has occurred (i.e., change of address, dependent is being adding).	Application
66	Other	Premium Adjustment Only	To indicate a premium adjustment only.	Monthly Reports

**1105 Standard Plan Waiting Period Codes**

Code	Waiting Period For:
01	Dependents (Spouse and Children) Only
02	All Family Members (Employee and Dependents)

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**CHAPTER 12 — AUTOMATED MONTHLY REPORTING**

This chapter is for employers who submit health  
Insurance reports to ETF via diskette.

**Future Automated Health Insurance Reporting Application**

As part of an initiative to fully automate the health insurance enrollment process and premium payment system in the future, ETF is developing a new Automated Health Insurance Reporting Application. The new application is likely to be Web based and, unlike the current application, should operate on all recent and future Windows platforms. In addition, ETF will provide a full range of tech support for the new application. Meantime, ETF plans to issue annual update diskettes for the current application until a new reporting system is available or until contractual and/or legislative changes to the Group Health Insurance Program require new premiums structures or reporting requirements beyond the functionality of the current application.

The current application was developed for use on a stand-alone, IBM-Compatible personal computer, running Microsoft Windows 3.1 or Windows for Workgroups 3.11, in standard VGA mode (640 x 480 pixels, 256 colors), with at least 8 MB of RAM and at least 25 MB of space available on drive C. While the application can be run in different environments, such as Microsoft Windows 95, Windows NT 3.51 or 4.0, IBM OS/2 Warp, or running Windows installed on a network, it may be more difficult to install and maintain without expert assistance.

- 1201 Introduction**
- 1202 Install Procedures**
- 1203 Reporting to ETF**
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**1201 Introduction**

This system was designed to provide employers with an efficient means of reporting the activity of employees participating in the State Employee Group Health Insurance Program. In addition, this system has been developed to assist employers in the

integration of reporting and financial systems. Use of this automated system enables ETF to develop and maintain an accurate and up-to-date database that ensures that employees receive their desired health insurance coverage upon request.

Employers continue to receive samples of any form revisions, as well as the yearly premium and carrier Summary and Monthly Coverage Report updates. On an annual basis, employers receive a diskette containing the next year's carrier and premium changes.

All Carrier Advance Copies of the *Group Health Insurance Applications* and the Carrier Copies of the Health Insurance Information Change and Transfer forms should be submitted directly to the health plans soon as possible prior to the anticipated effective date. Send ETF Advance Copies immediately to ETF. This enables ETF to pre-audit enrollment data prior to the effective date which decreases the number of premium adjustments made. In addition, once this information is entered into the database it will be used to verify the number and type of contracts reported for each carrier.

## 1202 Install Procedures

- A. Instructions for installing the application on a stand-alone PC running Windows 3.1 or Windows for Workgroups 3.11.
  1. Start Windows and close all other applications except the program manager.
  2. Insert **Disk 1** into drive A (or drive B).
  3. Choose **Run** from the **File** menu in the Windows Program Manager.
  4. Type **a:\setup** (or **b:\setup**) then choose **OK**.
  5. A screen will display asking whether to install or uninstall the program. Choose **Next**.
  6. A screen will display showing the setup options. Choose **Next**.
  7. Check the box in front of "ETF Health Reports." Choose **Next**.
  8. Follow the directions on the screen to load the remaining program diskettes.
  9. After choosing **Finish** at the end of the set-up procedure, remove the last diskette from the drive. Store the diskettes in a safe place.
  
- B. Instructions for installing the application on a stand-alone PC running Windows 95.
  1. Insert **Disk 1** into drive A (or drive B).
  2. Click on **Start**.
  3. Choose **Run**.
  4. Type **a:\setup** (or **b:\setup**) then choose **OK**.
  5. A screen will be displayed asking whether to install or uninstall the program. Choose **Next**.
  6. A screen will display showing the setup options. Choose **Next**.
  7. Check the box in front of "ETF Health Reports." Choose **Next**.
  8. Follow the directions on the screen to load the remaining program diskettes.
  9. After choosing **Finish** at the end of the set-up procedure, remove the last diskette from the drive. Store the diskettes in a safe place.
  
- C. Instructions for installing the application on a PC running Windows NT 3.51 or 4.0,

IBM OS/2 Warp, or running Windows from a network.

Contact ETF, Division of Trust Finance and Employer Services, Financial Operations Section, for specific instructions for loading the application on computer. The files must be loaded to different directories than the default directories in the program. Additionally, changes must be to the ODBC.INI file and to the properties of the application icons.

### 1203 Reporting to ETF

- A. On or before 4:30 p.m. of the designated due date, usually the 20th of the month preceding the coverage effective date, submit the following:
  - 1. Payment and/or applicable payment documentation.
  - 2. Paper copies of the following Reports:
    - NOTE: Samples and explanations of these Reports are included in Subchapter 1216.
    - a. The "State Health Insurance - Individual Carriers" generated for each carrier for whom contracts have been identified.
    - b. The "State Health Insurance – Adjustments." The Carrier plies of the Health Insurance Applications should be attached to the Adjustment Report(s).
    - c. The "State Health Insurance - Standard Totals," gives the total employee/employer share and the adjustment amount of the premiums collected for all contracts administered by ETF's ASO Contractor.
    - d. The "State Health Insurance - Alternate Totals," gives the total employee/employer share and the adjustment amount of the premiums collected for all HMO Contracts reported.
    - e. The "State Health Insurance - Grand Totals."
  - 3. The ETF plies of forms used in reporting any contract changes.
- B. Technical questions about the Automated Monthly Health Insurance Reporting System can be directed to ETF staff at (608) 267-9034. Questions concerning how to generate monthly health insurance reports using the Automated Monthly Health Insurance Reporting System can be directed to ETF staff at (608) 267-9034.

### 1204 A Few Tips Before Beginning

- A. Data must be entered in either the **white areas** of the Coverage Entry Screen or the **shaded areas** of the Adjustment or Premium Payment Entry Screen.
- B. Menu Options are accessed by using either the Mouse or by pressing the **Ctrl** key and the **first letter** of the **Option** selected.

EXAMPLE:        To activate the Print Option, hold down the **Ctrl** key while pressing **p**.
- C. Function Buttons identified within this application can be accessed by using either the Mouse or by pressing the **Alt** key and the **first letter** of the **Function** selected.

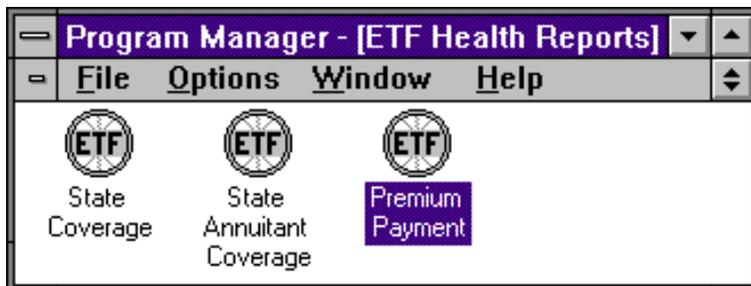
EXAMPLE: To activate the Adjustment Function (Alt Button) from the Coverage Entry Screen, hold down the **Alt** key while pressing **a**. To activate the Return Function (Return Button) in the Adjustment Entry Screen, hold down the **Alt** key while pressing **r**.

- D. To return to a previous data entry field, hold down the **Shift** key while pressing the **Tab** key.
- E. After data has been entered on a screen, **SAVE** that data before going to the next screen.
  - 1. **SAVE** after entering each record within the Adjustment Entry Screen.
  - 2. **SAVE** each updated Coverage Entry Screen by clicking on the **Save** function in the Menu Bar.

F. Do not rely on these instructions or the Application Diskettes to answer questions concerning enrollment, eligibility requirements or procedures.

## 1205 Icons

As a State Employer, the following Icons will automatically appear once this Application has been installed: The State Agency Coverage Icon, State Annuitant Coverage Icon, and the Premium Payment Icon.



*ETF Automated Monthly Health Insurance Reporting System.*

**State Coverage** Opens the Coverage Entry Screen and allows entry of the monthly coverage information by carrier for your current employees.

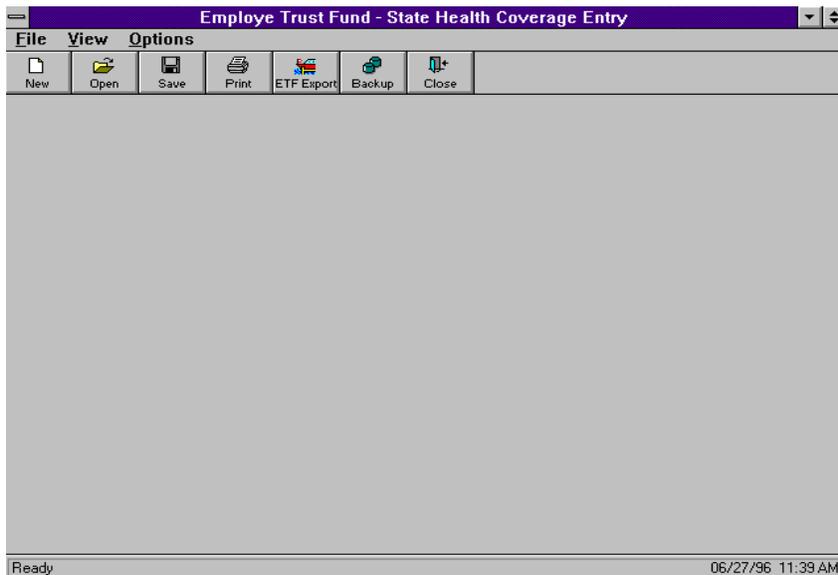
**State Annuitant Coverage** Opens the Coverage Entry Screen and allows entry of the monthly coverage information by carrier for your retired employees whose health insurance coverage is being paid from accumulated sick leave.

The State Annuitant Coverage icon can be deleted. To delete this icon, single click on the icon (which will highlight the icon). Press **Delete**. A window will pop up asking if you are sure that you want to delete the item. Press **Enter**.

NOTE: Contracts for your current employees cannot be entered in this icon.

**Premium Payment 1206 Main Screen** Opens the Payment Entry Screen and allows entry of payment information associated with the designated Monthly Coverage Reports.

After you have collected and audited all of the health insurance data for the month, you will want to begin entering the individual Carrier information into the Automated Health Insurance Reporting Application. Coverage information will have to be entered separately for your current employees and your retired (employer paid annuitants) employees (**See Subchapters 1207 and 1208**). Once you have double clicked on the State Coverage Icon the following **Main Screen** will appear.



*The Main Menu for State Health Coverage Entry System*

**Menu names on the menu bar:**

**File** **New**, **Open**, **Delete**, **Close**, **Print**, and **Save** commands.

**View** **Toolbars** and **Date and Time** commands.

**Options** **Roll Forward**, **Import Master File**, **ETF Export**, **Import Employer Data**, and **Backup** commands.

The following is a brief description of the commands found under each of the menu bar names listed above.

**File, New** Also accessed by clicking **New** on the button bar. If **New** is selected data must be entered into the following fields: Coverage Month, Coverage Year, EIN, Agency No., Group No. and Carrier Suffix.

**File, Open** Also accessed by clicking **Open** on the button bar. If **Open** is selected, a Pop-Up Window will appear indicating the Coverage Month, the current Coverage Year,

EIN, Agency No. and Group No. of previous reporting months. (See the Subchapter 610 for a description of this Pop-Up Window.)

**File, Delete** Deletes the current record shown on the Coverage Entry screen. If no record is showing, none is deleted. To delete all of the records for a given Coverage Month, each carrier must be displayed and deleted, one at a time.

**File, Close** Also accessed by clicking **Close** on the button bar. Closes the Automated Health Insurance program. Any changes to the screen must be saved before closing, otherwise, the changes will be lost.

**File, Print** Also accessed by clicking **Print** on the button bar. Opens the Print screen. (The **Print** command will be discussed later.)

**File, Save** Also accessed by clicking **Save** on the button bar. Saves all changes in the Coverage Entry screen. When the **Save** command is activated, a beep can be heard, and the message "Record Saved" is briefly displayed in the lower, left corner of the program screen.

**View, Toolbars** Allows the toolbar (the buttons below the menu bar) to be moved to other areas on the screen; or remove it from view completely.

**View, Date and Time** Removes the date and time display from the lower, right corner of the screen. It will re-appear when clicked on again.

**Options, Roll Forward** Creates the coverage entry screens for each carrier for next month's reports. The contract counts and employer/employee splits are carried forward automatically.

**Options, Import Master Files** Used to import new carrier names, new carrier rates, and/or new employer names into the application. Detailed instructions will accompany the diskette containing the update information.

**Options, ETF Export** Also accessed by clicking **ETF Export** on the button bar. Exports data for a given coverage month and year to a floppy disk. Two files are created: **loc\_cov.dbf** and **loc\_adj.dbf**.

**Options, Import Employer Data** May be used by employers with more than one agency number or group number. Imports health insurance data from a floppy disk containing the files created by the **ETF Export** function.

**Options, Backup** Backs up and reorganizes two files containing the health insurance database information: **etf.db** and **etf.log**. A copy of these files is placed in the root directory of drive C.

## 1207 Coverage Entry Screen for Active Employees

**Employee Trust Fund - State Health Coverage Entry**

File View Options

New Open Save Print ETF Export Backup Close

**State Health Insurance Coverage Entry**

Coverage Month: 8 Coverage Year: 1996

EIN: 1166 Agency No. 432000 Group No. 83510

Employer Name: AGING & LG. TERM CARE BD. ERA Next Prev Adj

Carrier Suffix: 02 Carrier Name: STANDARD PLAN II

	Single	Family	Grad Single	Grad Family
Last Month:	1	0	0	0
Additions:	0	0	0	0
Deletions:	0	0	0	0
Changes To:	0	0	0	0
Changes From:	0	0	0	0
Total:	1	0	0	0
Prem Amounts:	244.38	0.00	0.00	0.00

Prem Sub Total: 244.38 Adjustment: 0 Total Contracts: 1

Employee Share: 51.26 Employer Share: 193.12 Total: 244.38

Grand Total: 26 Total ERA: 9.60 Total Remit: 9769.06

Ready 06/27/96 1:32 PM

*This screen allows users to enter/edit/print Coverage records.*

### Buttons:

- Next** Selects the next Coverage Entry Screen containing data for a particular carrier which had been entered and saved. If the **Next** Button is not used to select the next carrier's Coverage Entry Screen, that button will become disabled until the Coverage Month is again accessed through the Coverage Pop-up Window.
- Prev** Selects the previous Coverage Entry Screen containing the data for a particular carrier which had been entered and saved. If the **Prev** (Previous) Button is not used to select the previous carrier's Coverage Entry Screen, that button will become disabled until the Coverage Month is again accessed through the Coverage Pop-up Window.
- Adj** Opens the Adjustment Screen.

**Fields:**

<b>Coverage Month</b>	Required	Insert the Coverage month (01-12), then press <b>ENTER</b> .
<b>Coverage Year</b>	Required	Insert the Coverage year (YYYY), then press <b>ENTER</b> .
<b>EIN</b>	Required	Insert the last seven digits of your Employer Identification Number (EIN). If your EIN is 69-036-1234-000, type 1234000, then press <b>ENTER</b> .
<b>Agency No.</b>	Required	Insert your six-digit Agency number, and press <b>ENTER</b> .
<b>Group No.</b>	Required	Insert your five-digit Group Number, and press <b>ENTER</b> .
<b>Employer Name</b>	Displayed	Corresponds to the inserted <b>EIN</b> .
<b>Carrier Suffix</b>	Required	Insert the applicable carrier code, and press the <b>TAB</b> key.
<b>Carrier Name</b>	Displayed	Corresponds to the inserted <b>Carrier Suffix</b> .
<b>Sngl Last MT</b>	Required	Total of last month's Single Contracts.
<b>Sngl Adds</b>	Displayed	Total of Single Contracts entered as Additions on the Coverage Entry Adjustment Screen.
<b>Sngl Dels</b>	Displayed	Total of Single Contracts entered as Deletions on the Coverage Entry Adjustment Screen.
<b>Sngl Chgs To</b>	Displayed	Total of Single Contracts entered as Changes To on the Coverage Entry Adjustment Screen.
<b>Sngl Chgs From</b>	Displayed	Total of Single Contracts entered as Changes From on the Coverage Entry Adjustment Screen.
<b>Sngl Total</b>	Displayed	Total Single Contracts. (Once <b>SAVED</b> and the <b>Roll Forward</b> Function activated, this <u>Total</u> will become the next month's beginning Contracts.)
<b>Sngl Prem Amt</b>	Displayed	Total premiums reported for Single Contracts.
<b>Fmly Last MT</b>	Required	Total of last month's Family Contracts.
<b>Fmly Adds</b>	Displayed	Total of Family Contracts entered as Additions on the Coverage Entry Adjustment Screen.

<b>Fmly Dels</b>	Displayed	Total of Family Contracts entered as Deletions on the Coverage Entry Adjustment Screen.
<b>Fmly Chgs To</b>	Displayed	Total of Family Contracts entered as Changes To on the Coverage Entry Adjustment Screen
<b>Fmly Chgs From</b>	Displayed	Total of Family Contracts entered as Changes From on the Coverage Entry Adjustment Screen
<b>Fmly Total</b>	Displayed	Total Family Contracts. (Once SAVE and the <b>Roll Forward</b> Function activated, this <b>Total</b> will become the next month's beginning Contracts.)
<b>Fmly Prem Amt</b>	Displayed	Total premiums for Family Contracts reported for the designated Coverage Month.
<b>Prem Sub Total</b>	Displayed	Sub-Total of this Carrier's premium amount.
<b>Adjustment</b>	Displayed	Total Premium Adjustment amount for this Carrier for the designated Coverage Month.
<b>Total Contracts</b>	Displayed	Total of Contracts reported for this Carrier for the designated Coverage Month.
<b>Employee Share</b>	Required	Insert the Total Employee Share for the Contracts reported for the designated Coverage Month for this Carrier. This amount should include the Employee Share of any Adjustments reported for this Carrier for the designated Coverage Month.
<b>Employer Share</b>	Required	Insert the Total Employer Share for the Contracts reported for the designated Coverage Month for this Carrier. This amount should include the Employer Share of any Adjustments reported for this Carrier for the designated Coverage Month.
<b>Total</b>	Displayed	Sum of Employer and Employee Share amounts, including the Adjustment amounts for this Carrier for the designated Coverage Month.
	NOTE:	If this Total does not equal of the sum of the inserted Employee and Employer Shares, a warning will appear.
<b>Grand Total</b>	Displayed	Accumulated total of Contracts reported for the designated Coverage Month.
<b>Total Remit</b>	Displayed	Total amount payable to ETF for all reported Health Insurance Contracts for the designated Coverage Month.

## 1208 Coverage Entry Adjustment Screen for Active Employees

Adjustment Type	Enroll Type	Employee Type	Soc Sec Number	Effective Date	Old Contract	New Contract	Premium Adj Begin Month (MM/YY)	Premium Adj End Month (MM/YY)	Premium Adj Amount	Comments
Add	0	0	123-45-6789	09/30/96	0	2	00/00	00/00	0	Peach, Amy E.
Add	0	0	234-56-7890	09/30/96	0	2	00/00	00/00	0	Apple, Jonathon C.

Add Total	Delete Total	Change To Total	Change From Total	Adj. Total
4	0	0	0	0.00

*This Screen allows users to enter or edit Adjustment records (Add, Change, Delete or Premium Only).*

### **Buttons:**

- Insert**      Opens fields to allow data-entry of adjustment information. A highlighted area and a Pull Down Arrow will automatically appear at the Adjustment Type field where your first entry must occur.
- Delete**     Deletes the entire selected adjustment record.
- Save**        Saves all adjustment records. A prompt will occur indicating that the information has been saved. This **Save** function pertains to the Save Button which is located between the **Delete** and **Return** Buttons.
- Return**      Returns to the Coverage Entry Screen and updates the Coverage Counts and Total amounts.

### **Fields:**

- Employer Name**      Displayed      Employer Name.
- Carrier Name**        Displayed      Carrier Name.

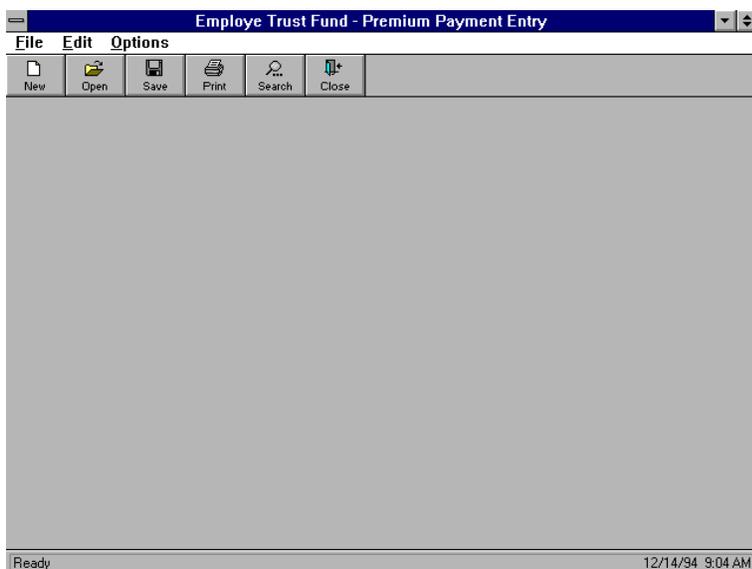
<b>Adjustment Type</b>	Required	<p>Type a valid Adjustment Type, or click on the Pull Down Arrow to display applicable Adjustment Types via a Pull Down Window. (Only the codes appear; there was not ample room to include the descriptions.) Once the Adjustment Type has been typed, press the <b>TAB</b> key to proceed to the next data-entry field.</p> <p>Additions can be identified by an <b>A</b>. The <i>Hire</i> or <i>Rehire</i> Date must be typed in the Comment section. Changes To and From can be identified by a <b>C</b>. Deletions can be identified by a <b>D</b>. The <i>Date of Birth</i> must be typed in the Comments section. Premium Only adjustments can be identified by a <b>P</b>.</p> <p>NOTE: Premium Only Adjustments will be automatically carried to succeeding months if the Roll Forward Option is instituted. (Refer to Subchapter 614 for a description of the Roll Forward Option.) The other Adjustment Types must be entered on a monthly basis.</p>
<b>Enroll Type</b>	Required	
<b>Employee Type</b>	Required	<p>Insert a valid Employee Type, or click on the Pull Down Arrow to display applicable Employee Types via a Pull Down Window. (Only the codes appear; there was not ample room to include the descriptions.) Once the Employee Type has been inserted, press the <b>TAB</b> key to proceed to the next data-entry field.</p>
<b>Soc Sec Number</b>	Required	<p>Insert the employee's Social Security Number <u>without dashes</u>, and press the <b>TAB</b> key to proceed to the next data-entry field.</p>
<b>Effective Date</b>	Required	<p>Insert the Effective Date <u>without slash marks</u> for the indicated Adjustment Type. Dates must be entered as follows: <b>MMDDYY</b>. Once the Effective Date has been entered, press the <b>TAB</b> key to proceed to the next data-entry field.</p>
<b>Old Contract</b>	Required	<p>Insert the Old Contract Type Code in the case of a <b>Change</b> and/or <b>Deletion Adjustment Entry</b>. In the case of an <b>Addition Adjustment Entry</b>, a "0" will automatically appear in the Old Contract field.</p> <p>Insert an Old Contract Code or click on the Pull Down Arrow to display applicable Contract Types via a Pull Down Window. (Only the codes appear; there was not ample room to include the descriptions.) Once the Old Contract Type Code has been inserted, press the <b>TAB</b> key.</p>

<b>New Contract</b>	Required	<p>Insert the New Contract Type Code in the case of a <b>Change</b> and/or <b>Addition Adjustment Entry</b>. In the case of a <b>Deletion Adjustment Entry</b>, a "0" will automatically appear in the New Contract Type field.</p> <p>Insert a New Contract Type or click on the Pull Down Arrow to display applicable Contract Types via a Pull Down Window. (Only the codes appear; there was not ample room to include descriptions.) Once the New Contract Type Code has been inserted, press the <b>TAB</b> key to proceed to the next data-entry field.</p>
<b>Premium Adj Begin MT</b>	Required	<p>(Used only if the adjustment starts before the current month.) Insert the Adjustment Begin Month, and Year in the following format: <b>MM/YY</b>. <u>The slash will automatically appear.</u> If the Adjustment is only for the current month, insert the month and year in this field and <b>TAB</b> through the Premium Adjustment End Month field.</p>
<b>Premium Adj End MT</b>	Required	<p>(Used only if the adjustment starts before the current month, and the adjustment is for more than one month.) Insert the Adjustment End Month, and year in the following format: <b>MM/YY</b>. <u>The slash will automatically appear.</u></p>
<b>Premium Adj Amount</b>	Required	<p>Insert any premium adjustment amounts. (The default is zero.) <u>When reporting a credit amount, a <b>negative sign</b> must appear first.</u> For example, a refund would appear as "-192.14".</p>
<b>Comments</b>	Required	<p>Used to include the subscriber's name (type <b>Last name, first initial</b>), explanation of premium only adjustments, or information pertaining to spouse-to-spouse transfers, Additions and Deletions.</p> <p><u>If the Adjustment is an <b>Addition Adjustment Entry</b>, insert the <b>Hire or Rehire Date</b>. If the adjustment is a <b>Deletion Adjustment Entry</b>, insert the <b>Birthdate</b> in this field.</u></p>
<b>Add Total</b>	Displayed	Total number of Contracts indicated as Additions.
<b>Delete Total</b>	Displayed	Total number of Contracts indicated as Deletions.
<b>Change To Total</b>	Displayed	Total number of Contracts indicated as Changed To.
<b>Change From Total</b>	Displayed	Total number of Contracts indicated as Changed From.

**Adj. Total**      Displayed      Total dollar amount of all Adjustment Entries in which premium adjustments were entered.

## 1209 Entering Payment Information

- A. Select the Premium Payment Icon in Program Manager - [ETF Health Reports] to open the Premium Payment Entry Screen and allow entry of payment information associated with the designated Monthly Coverage Reports.
  
- B. The Main Menu for the Premium Payment Entry System is activated.



### Menu names on the menu bar:

- File**              **New, Open, Delete, Close, Print,** and **Save** commands.
  
- View**             **Toolbars** and **Date and Time** commands.
  
- Options**         **Export Payment Data, Import Master Files,** and **Backup** commands.

The following is a brief description of the commands found under each of the menu bar names listed above.

- File, New...**      Also accessed by clicking **New** on the button bar. Opens the Premium Payment Entry screen and allows entry of new records. Used when an employer first begins using the automated system for detailing premium payment information.
  
- File, Open...**    Also accessed by clicking **Open** on the button bar. If **Open** is selected, a Pop-Up Window will appear indicating the Coverage Month, the current Coverage Year, EIN, Agency No. and Group No. of previous reporting

months. (See E. of this Subchapter for a description of the Pop-Up Window.)

- File, Delete** Deletes the current record shown on the Premium Payment Entry screen. If no record is showing, none is deleted.
- File, Close** Also accessed by clicking **Close** on the button bar. Closes the Premium Payment Entry System program. Any changes to the screen must be saved before closing, otherwise, the changes will be lost.
- File, Print...** Also accessed by clicking **Print** on the button bar. Opens the Print screen. (See Subchapter 1212 on Print a complete description.)
- File, Save** Also accessed by clicking **Save** on the button bar. Saves all changes in the Premium Payment Entry screen. When the **Save** command is activated, a beep can be heard, and the message "Record saved" is briefing displayed in the lower, left corner of the program screen.
- View, Toolbars** Allows the tool bar (the buttons below the menu bar) to be moved to other areas on the screen, or even remove it from view completely.
- View, Date and Time** Removes the date and time display from the lower, right corner of the screen. It will re-appear when clicked on again.
- Options, Export Payment Data** Also accessed by clicking **ETF Export** on the button bar. Exports data for a given coverage month and year to a floppy disk. One file is created: **payment.dat**. (See Subchapter 1211 on Export for a complete description.)
- Options, Import Master Files** Used to import new carrier names, new carrier rates, and/or new employer names into the application. Detailed instructions will accompany the diskette containing the update information.
- Options, Backup** Backs up and reorganizes two files containing the health insurance database information: **etf.db** and **etf.log**. A copy of these files is placed in the root directory of drive C.

**C. Premium Payment Entry Screen**

Screen allows users to enter/edit/print Premium Payment records.

**Buttons:**

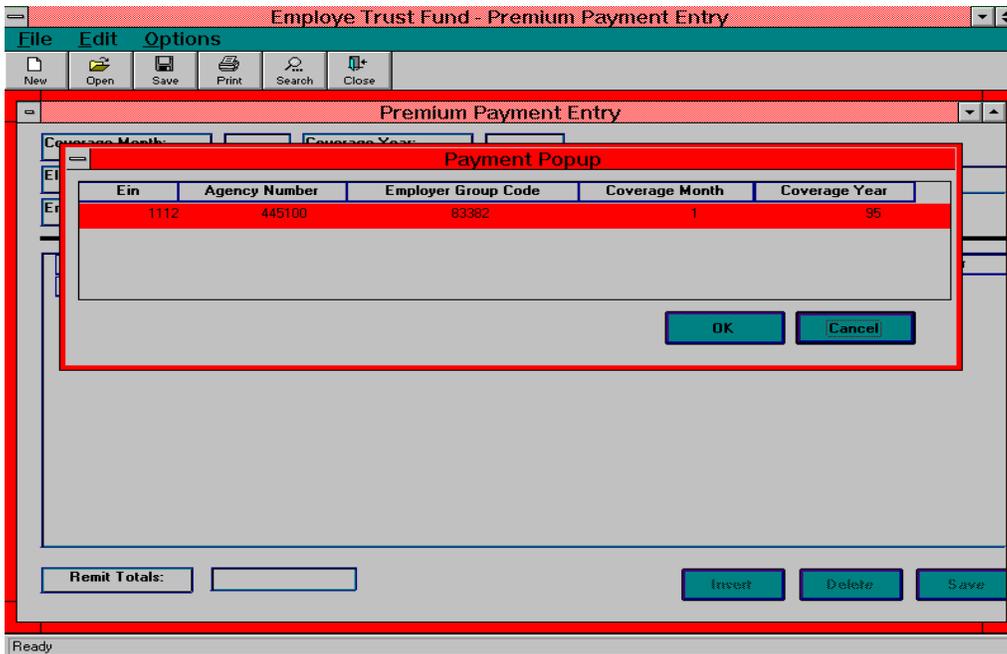
- Insert**      Inserts a blank record and allows users to fill in the empty fields with premium payment information.
  
- Delete**      Removes the entire record from the database. Click anywhere between the fields of the record to highlight the entire record. Click the **Delete** button to remove the record.
  
- Save**          Saves keyed records to the database. Click on the **Save** button after each new record is added, and after making changes to any existing records. Save the current record before starting to work on a different record.

**Fields:**

- Coverage Month**      Required      Insert the Coverage month (01-12), then press **ENTER**.
  
- Coverage Year**      Required      Insert the Coverage year (YYYY), then press **ENTER**.
  
- EIN**                  Required      Insert the last seven digits of your Employer Identification Number (EIN). If your EIN is 69-036-1234-000 type 1234000, then press **ENTER**.

<b>Agency No.</b>	Required	Insert your six-digit Agency number, and press <b>ENTER</b> .
<b>Group No.</b>	Required	Insert your five-digit Group number, and press <b>ENTER</b> .
<b>Employer Name</b>	Displayed	Corresponds to the inserted EIN.
<b>Transaction Date</b>	Required	Enter the Transaction date of your choice. Dates must be entered as follows: MMDDYY. Do not enter the slashes. They will automatically appear.
<b>Transaction Code</b>	Required	Enter a Transaction code of your choice (i.e. check, payment voucher, etc.).
<b>Trans. Agcy. Num.</b>	Required	Enter your internal Transaction Agency number.
<b>Identification Num.</b>	Not Required	Enter your transaction Identification number (i.e., Check number, voucher number, etc.).
<b>Batch Number</b>	Not Required	Enter a Batch number, if applicable.
<b>Payment Amount</b>	Required	Enter the Total Payment amount.
<b>Memo</b>	Not Required	Enter a description of the payment.
<b>Remit Total</b>	Displayed	Carries forth the Remit Total of all of the Coverage Entry screens for the designated Coverage Month.

- D. **Premium Payment Pop-Up Window** allows users to scroll through existing Premium Payment Records, highlighting the Record to be selected for entry or viewing.



*The Payment Pop-Up Window is activated when clicking on the **Open** Button in the **Main Menu** of the Premium Payment Entry System.*

**Buttons:**

- Arrows**                      Scrolls the Records forward or backward in EIN numerical order.
- OK**                              Opens the highlighted Records.
- Cancel**                         Exits the Payment Pop-Up Window.

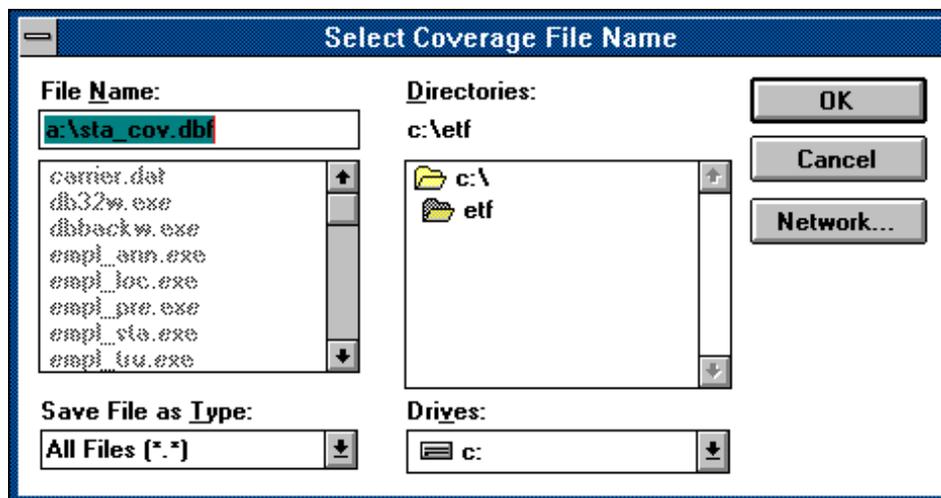
**1210 Export**

- A. This function extracts data for the given month from the health insurance database on your PC. Two files are copied to a diskette to be submitted to ETF. These files will be uploaded to ETF's Health Insurance Reporting System database.
- B. To download your monthly coverage and adjustment information to a diskette for submission to ETF do the following:

1. Click on the **ETF Export button**, or select from the menu bar **Options** and select *Export*. The Export MM-YYYY Window will appear.



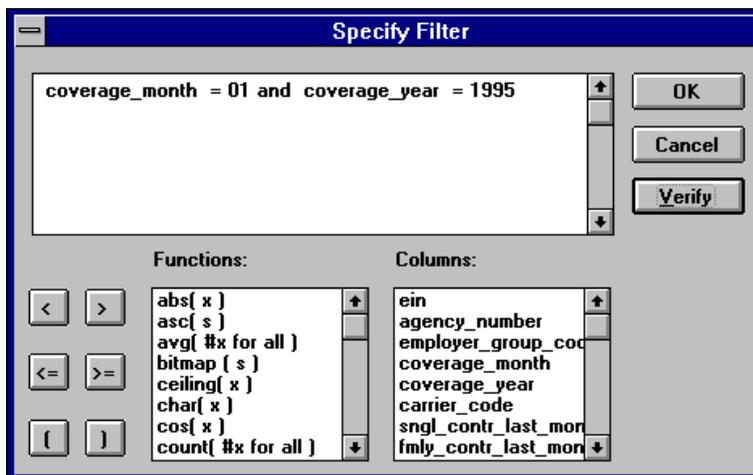
2. Insert the Coverage Month containing the data you have selected to be exported in the Export Month field using the (01-12) format, press **TAB** and insert the Export Year (YYYY), then click on **OK**.



3. Insert a diskette into drive A (1.44MB High Density [HD] formatted for IBM).  
NOTE: The application automatically identifies the coverage data file **loc\_cov.dat** or **loc\_acov.dat** to be downloaded to drive A. Click on **OK**. The adjustment data file **loc\_adj.dat** or **loc\_aadj.dat** data will automatically be identified and downloaded to drive A after clicking on **OK**.
4. When the "ENTER EXPORT MM-YYYY" window disappears and the light on the Floppy Disk Drive goes out, your Monthly Coverage, Adjustment, and/or Payment information will have been copied to the diskette in drive A for delivery to ETF.  
NOTE: You have the option of downloading your files to different drives and directories.

## 1211 Print

- A. Allows the user to select and print Coverage Reports and detailed Adjustment Reports. (Samples of these Reports are included in Subchapter 616.) The user will also be able to specify records to be printed and change the sort order. Users can view reports on-line, export the data to a file and/or print reports.
- B. To activate the **Print Function**, do the following:
  1. Click on **Print** in the Menu Bar.
  2. A screen will appear that says "Report Selection." Use the Pull Down Arrow to select the Report to be printed. Once the Report has been highlighted and released it will display in the "Selected Report" field.
  3. A screen will appear which has the heading of the report selected. To be able to view the entire report, click on **Display** and select **Preview Mode**.
  4. To select specific records to be printed:
    - a. Click on **Rows** and select **Filter**. A Pop-Up Window will appear which has the heading "Specify Filter."



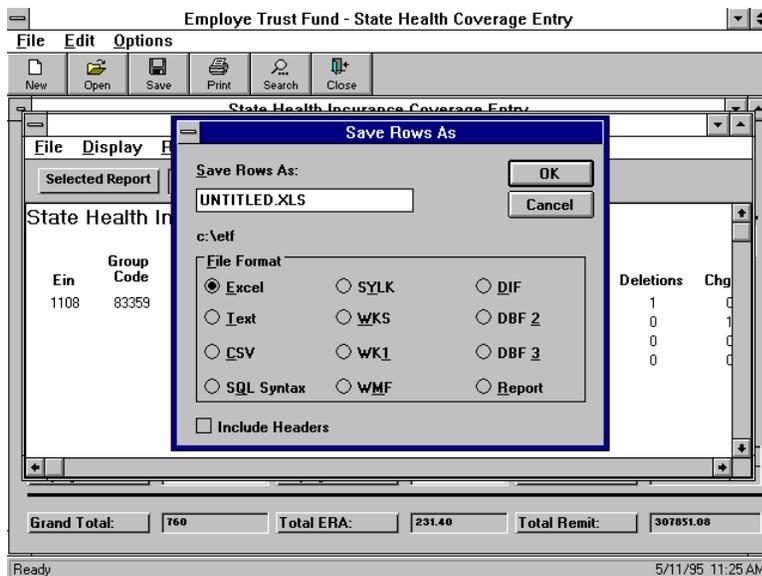
- b. Highlight and single click on the "**coverage\_month**" within the Columns box. This will display within a data-entry window. Type "=" followed by the designated coverage month (**MM**). Type "**and**."
          - c. Highlight and single click on the "**coverage\_year**" within the Columns box. This will also display within the data-entry window. Type "=" followed by the designated coverage year (**YYYY**).
          - d. The following should appear in the window "**coverage\_month = MM and coverage\_year = YYYY**". Click on **OK**.  
NOTE: You can filter using any category; this is the most common.
5. **IMPORTANT:** To update the output to reflect the previously executed filtering function:
  - a. Click on **Display**.
  - b. Select **Preview Mode**.
  - c. Click on **Rows**.
  - d. Select **Retrieve**.

Completion of this process will ensure that only the information previously selected (Filtered) will be printed.

6. To execute the **Printing**, click on **File** and highlight **Print**.
7. To Close, click on **File** and highlight **Close**.

## 1212 Report Formatting

- A. Allows the user to save the Coverage and Adjustment information previously identified within the filtering process of the **Print Function** into a different application (i.e., Excel, Lotus, Paradox, etc.).

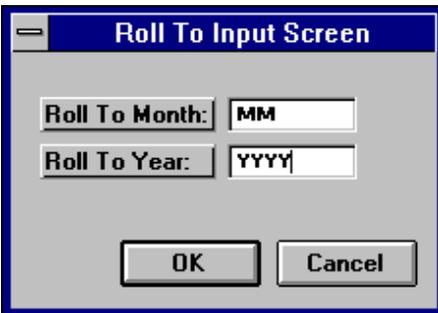


- B. To activate the **Formatting Function**, do the following:
  1. Click on **Print** in the Menu Bar.
  2. Select a **Report** using the Pull Down Arrow.
  3. Click on **Rows**.
  4. Select **Save Rows As**.
  5. Select the file format to be used, and click on **OK**.

## 1213 Roll Forward

- A. Allows the user to roll forward prior months' ending contract counts into the current month's beginning contract counts within each Carrier's Coverage Entry Screen. Also, recurring Premium Only Adjustments will roll forward to the next designated month.
- B. To activate the **Roll Forward Function**, do the following:

1. Click on **Options** and select **Roll Forward**.
2. Once the Coverage Pop-Up appears, highlight the month containing the data to be carried forward. Click on **OK**.
3. A window will appear in which you need to type the month (MM) and year (YYYY) you want to roll forward to. Click on **OK**.



4. Another message will appear stating that the *Roll Forward* has been completed.

## 1214 Back-Up

- A. This function will restructure the ETF database as well as store a copy of the database in the root directory of drive C. A backup should be performed each month after completing the creation of the export diskette and paper reports.
- B. Click on the **Backup** button, or select from the menu bar **Options** and select *Backup*. The **etf.db** and **etf.log** files will be rebuilt to optimize performance, and are copied to the root directory of drive C. A window will pop-up displaying the progress of the backup.

## 1215 Generation of Paper Copies of Reports

- A. State Health Insurance - Individual Carriers (i.e., Monthly Coverage Reports)
  1. Each Carrier for which you report Contracts for will result in the generation of a State Health Insurance - Individual Carrier Report. A page break will appear after the totals are printed for the previous Carrier.
  2. Your *EIN, Group Number, Agency Number, Employer Name, Coverage Month/Year, Carrier Code, and Carrier Name* will appear on each page of the Report.
  3. The *Last Month* column represents the number of Contracts for each type of coverage (i.e., Single, Family, etc.) reported for the previous month.
  4. The **Number** and **Type** of Adjustments (i.e., *Additions, Deletions, Chg To* and/or *Chg From*) generated during the designated Coverage Month will be displayed.
  5. *Total Contracts* represents the sum of the previous month's Contracts by type plus or minus any Adjustments reported this month.
  6. *Premiums* represents the number of contracts multiplied by the rate for each contract type.

7. **Total Contracts** is the sum of each type of Contract reported for the designated Carrier.
8. **Total Premiums** represents the sum of all *Premiums* reported for the designated Carrier.
9. **Employer Share** is the amount the employer contributes towards the *Premiums* for the Contracts reported for this particular Carrier.
10. **Employee Share** is the amount employees contributed towards the *Premiums* for the Contracts reported for this particular Carrier.
11. **Grand Total** is the sum of the **Employer** and **Employee Shares**, including any premium adjustments, reported for this particular Carrier.
12. **Total Adj** represents the sum of any premium adjustments due to when the Adjustment Contracts were reported for this Carrier.



- B. State Health Insurance - Adjustments (i.e., Monthly Additions, Changes and Deletions Reports)
1. If you report any type of Adjustment Contracts for a Carrier, a State Health Insurance - Adjustment Report will be generated. A page break will occur at the end of the Adjustments reported for each Carrier.
  2. Your *EIN, Group Number, Agency Number, Employer Name, Coverage Month/Year, Carrier Code* and *Carrier Name* will appear on each page of the Report.
  3. **Adj Type** represents the type of Adjustment (i.e., A for Addition; D for Deletion; C for Changes; and P for Premium Adjustment Only) being reported by subscriber.
  4. **Enrl Type** represents the reason for the adjustment being reported.
  5. **Emp Type** defines the subscriber's status (i.e. State Employee, etc.).
  6. **Soc Sec No** is the subscriber's social security number.
  7. **Effc Dt** represents the date that the designated Adjustment Type took effect. The **Memo** field provides additional information to explain or identify the adjustment being reported for this subscriber.
  8. **Old Code** represents the type of Contract (i.e., 1 for Single; 2 for Family; 0 for None) previously held by the subscriber for Changes or Deletions.
  9. **New Code** represents the type of Contract (i.e., 1 for Single; 2 for Family; 0 for None) for Changes or Additions.
  10. **Begin MM/YY** represents the date the change in the subscriber's level of coverage (i.e., Single or Family) occurred.
  11. **End MM/YY** represents the date the change in the subscriber's level of coverage (i.e., Single or Family) ends.
  12. **Adj Amount** represents any premium adjustments which are the result of the timing associated with the reporting of an Adjustment.
  13. **Totals** represents the sum of the Adjustment Amounts reported for the Carrier.

State Health Insurance - Adjustments Sample

State Health Insurance - Adjustments

Ein	Group Number	Agency Number	Employer Name	Adj. Type	Empl. Type	Emp. Type	Coverage Month/Year			Carrier Code	Carrier Name	New Code	Begin MM/YY	End MM/YY	Adj. Amount
							Sec No.	Sec No.	Eff. Dt.						
1173	83516	399000	WI CONSERVATION CORPS BD.	A	2	2	8	1996	15	DEANCARE					
							123-45-6789	07/01/96	0	1	07/96	00/00	191.06		
									Adams, J. - hired 7/01/96						
1173	83516	399000	WI CONSERVATION CORPS BD.	C	43	2	8	1996	15	DEANCARE					
							246-80-2468	08/03/96	1	2	00/00	00/00	0.00		
									Washington, G. - married 8/03/96						
													Totals:	191.06	

- C. State Health Insurance - Standard Totals - Standard Totals
1. If you report any contracts within the Standard Plan (01), Standard Plan II (02), or SMP (05), this report will be generated representing the sum total of all the amounts reported for these Carrier Suffixes.
  2. Your *EIN*, *Group Number*, *Agency Number*, *Employer Name*, and *Coverage Month/Year* will appear on the single page Report.
  3. The *Last Month* column represents the number of Contracts for each type of coverage (i.e., Single, Family, etc.) reported for the previous month.
  4. The **Number** and **Type** of Adjustments (i.e., Additions, Deletions, Chg To and/or Chg From) that were generated during the designated Coverage Month will be displayed.
  5. *Total Contracts* represents the sum of all previous month's Contracts by type plus any Adjustments reported this month.
  6. *Premiums* represents the number of contracts multiplied by the rate for each contract type.
  7. **Total Contracts** is the sum of each type of Contract reported for these Carrier Suffixes.
  8. **Total Premiums** represents the sum of *Premiums* reported for these designated Carrier Suffixes.
  9. **Employer Share** is the amount the employer contributes towards the *Premiums* for the Contracts reported for these particular Carrier Suffixes.
  10. **Employee Share** is the amount employees contributed towards the *Premiums* for the Contracts reported for these particular Carrier Suffixes.
  11. **Grand Total** is the sum of the *Employer* and *Employee Shares*, including any premium adjustments, reported for these particular Carrier Suffixes.
  12. **Total Adj** represents the sum of any premium adjustments due to when the Adjustment Contracts were reported for these particular Carrier Suffixes.



D. State Health Insurance - Alternate Totals

1. If you report any Contracts for participating HMO's, this Report will be generated representing the sum total of all the amounts reported for those Contracts depicting HMO coverage.
2. Your *EIN*, *Group Number*, *Agency Number*, *Employer Name*, and *Coverage Month/Year* will appear on the single page Report.
3. The *Last Month* column represents the number of Contracts for each type of coverage (i.e., Single, Family, etc.) reported for the previous month.
4. The **Number** and **Type** of Adjustments (i.e., Additions, Deletions, Chg To and/or Chg From) that were generated during the designated Coverage Month will be displayed.
5. *Total Contracts* represents the sum of all previous month's Contracts by type plus any Adjustments reported this month.
6. *Premiums* represents the number of contracts multiplied by the rate for each contract type.
7. **Total Contracts** is the sum of each type of Contract reported for the HMO Carriers.
8. **Total Premiums** represents the sum of *Premiums* reported for the HMO Carriers.
9. **Employer Share** is the amount the employer contributes towards the *Premiums* for the Contracts reported for the HMO Carriers.
10. **Employee Share** is the amount employees contributed towards the *Premiums* for the Contracts reported for the HMO Carriers.
11. **Grand Total** is the sum of the *Employer* and *Employee Shares*, including any premium adjustments, reported for the HMO Carriers.
12. **Total Adj** represents the sum of any premium adjustments due to when the Adjustment Contracts were reported for the HMO Carriers.



- E. State Health Insurance - Grand Totals (i.e., Monthly Summary Reports)
1. This Report represents all the Contractual and Premium information for all the Carriers reported during the designated Coverage Month.
  2. Your *EIN*, *Group Number*, *Agency Number*, *Employer Name*, and *Coverage Month/Year* will appear on the single page Report.
  3. The *Last Month* column represents the number of Contracts for each type of coverage (i.e., Single, Family, etc.) reported for the previous month.
  4. The **Number** and **Type** of Adjustments (i.e., Additions, Deletions, Chg To and/or Chg From) that were generated during the designated Coverage Month will be displayed.
  5. *Total Contracts* represents the sum of all previous month's Contracts by type plus any Adjustments reported this month.
  6. *Premiums* represents the number of contracts multiplied by the rate for each contract type.
  7. **Total Contracts** represents the sum of all Contracts reported for all Carriers.
  8. **Total Premiums** represents the sum of *Premiums* reported for all Carriers.
  9. **Employer Share** is the amount the employer contributes towards the *Premiums* for the Contracts reported for all Carriers.
  10. **Employee Share** is the amount employees contributed towards the *Premiums* for the Contracts reported for all Carriers.
  11. **Grand Total** is the sum of the *Employer* and *Employee Shares*, including any premium adjustments, reported for all Carriers.
  12. **Total Adj** represents the sum of any premium adjustments for all Carriers due to when the Adjustment Contracts were reported.

State Health Insurance - Grand Totals Sample

State Health Insurance - Grand Totals

Ein	Group Number	Agency Number	Employer Name	Last Month	Coverage Month/Year		Additions	Deletions	Chg To	Chg From	Total Contr	Premiums
					8	1996						
1173	83516	395000	WI CONSERVATION CORPUS BD.									
				Sngl: 23		1	0	0	-2	22	4,414.72	69 Total Contracts
				Fmly: 45		0	0	2	0	47	23,367.28	27,782.00 Total Premiums
				Grad Sngl: 0		0	0	0	0	0	0.00	27,272.08 Employee Share
				Grad Fmly: 0		0	0	0	0	0	0.00	700.98 Employee Share
												27,973.06 Sub-Total
												42.60 ERA Amount
												28,015.66 Grand Total
												191.06 Total Adj.

**Department of Employee Trust Funds**  
**STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 13 — REFERENCE**

**1301 Forms**  
**1302 Acronyms**

**1301 Forms**

Forms referenced in this manual are listed in the chart below in numeric order by form number. Refer to Subchapter 109 for information on ordering forms.

<b>Form Number</b>	<b>Form Name</b>	<b>Referenced in Subchapter(s)</b>
ET-1127	WRS Administration Manual	901
ET-1607	Monthly Coverage Report	411, 412, 501, 502, 504, 505, 506, 507
ET-1608	Health Insurance Summary	501, 505, 506, 507, 508, 511
ET-2119	Your Benefit Handbook	109
ET-2107	It's Your Choice (State Employees)	102, 103, 108, 203, 206, 207,
ET-2127	It's Your Choice (UW Graduate Assistants)	302, 306, 309, 311, 401, 403
ET-2143	SMP – State Employees	108
ET-2112	Standard Plan – State Employees	108
ET-2301	Group Health Insurance Application	303, 306, 307, 308, 309, 310, 311, 314, 401, 402, 403, 404, 406, 407, 408, 411, 413, 414,
ET-2302	Graduate Assistants	502, 503, 504, 507, 605, 608, 701, 802, 902, 903, 1001
ET-2304	Life Insurance Application/Cancellation/Refusal	903
ET-2307	Income Continuation Insurance Application	903
ET-2311	Continuation – Conversion Notice	108, 315, 401, 411, 503, 504, 508, 602, 603, 604, 605, 608, 609, 701
ET-2319	Rehired Annuitant Election	901, 902
ET-2325	Converting Your Group Life Insurance to Pay Health or Long-Term Care Insurance Premiums	704
ET-2329	Health Insurance Information Change	108, 406, 407, 408, 409, 410, 608, 707
ET-2405	Insurance Complaint	104, 105, 108
ET-2610	Monthly Additions Report	401, 501, 502, 504, 505, 507, 511
ET-2612	Monthly Deletions Report	401, 411, 412, 413, 501, 502, 503, 504, 505, 507, 807
ET-2614	Monthly Changes Report	501, 504, 505, 507, 511
ET-4112	Group Health Insurance for Retirees	701, 702
ET-4305	Sick Leave Escrow Application	704, 809

Form Number	Form Name	Referenced in Subchapter(s)
ET-4306	Accumulated Leave Certification	411, 503, 802, 804, 805, 807, 1001
ET-4307	Medicare Eligibility Statement	703
ET-4814	Employer Verification of Health Insurance Coverage	602
ET-6101	Death Benefits	108

### 1302 Acronyms

The following acronyms are used in this manual:

COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
EIN	Employer Identification Number
ETF	Department of Employee Trust Funds
FMLA	Family Medical Leave of Absence
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
ID	Identification
LOA	Leave of Absence
LTDI	Long-Term Disability Insurance
PBM	Pharmacy Benefit Manager
PPP	Preferred Provider Plan
SMP	State Maintenance Plan
WRS	Wisconsin Retirement System