



Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report

Wisconsin Department of Employee Trust Funds
 801 W. Badger Road
 Madison, WI 53707-7931
 1-877-533-5020 (toll-free)
 Fax: 608-267-4549
etf.wi.gov

See Instructions on Page 2 for assistance. Please print.			
Part A: Employer Verification of Health Insurance Coverage			
Health plan: _____			
Monthly premium: \$ _____	Coverage type: <input type="checkbox"/> Single <input type="checkbox"/> Family		
Coverage as an <i>active employee</i> ends on? (mm/dd/ccyy) _____			
Will premiums be paid by the <i>employer</i> after termination/retirement?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes , employer must complete and submit Section C of this form at least two months prior to the date when the employer contribution for premiums will end.			
Note: To qualify as a local employer paid annuitant, the employer <i>must</i> pay a portion of the total premium due.			
Employer number: 69-036-	Employer name: _____		
Signature of employer representative: _____	Date: (mm/dd/ccyy) _____	Phone number: _____	
Part B: Employee Information			
I wish to continue my health insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No (If no , please note that currently there are no re-enrollment opportunities for the Wisconsin Public Employer's Group Health Insurance Program.)			
Employee name: _____	Employee SSN: _____ DOB: (mm/dd/ccyy) _____		
Address: Street No. _____	City _____	State _____	ZIP Code _____
Spouse/domestic partner/dependent/survivor name (last, first, MI) _____		SSN: _____ DOB (mm/dd/ccyy) _____	
Signature of employee: _____		Date: (mm/dd/ccyy) _____	
Part C: Transfer Report (Local paid annuitant no longer receiving employer contributions.)			
Employee name: _____		SSN/Member ID: _____	
DOB: _____ (mm/dd/ccyy) Gender: ____ Health plan: _____			
Date coverage ends (employer contributions to premiums cease): _____ (mm/dd/ccyy)			

Employer: Keep a copy of this form for your records and make a copy for your employee.





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INSTRUCTIONS

Employer: Please enter your employer number and employer name at the top of the form.

Please complete **Part A** of this form and have your employee complete the **Employee** section. If your employee is changing their coverage level, they must also submit a *Health Insurance Application* (ET-2301) as well.

Please have your retiring employee complete **Part B** of this form. If the person completing the form is the surviving spouse/domestic partner, have them complete the employee part as the employee would have.

Please complete **Part C** of this form if/when you are **no longer** paying a portion of the employee's health insurance premium and submit to ETF at least two months prior to premium contributions ending.

It is the responsibility of the annuitant to submit a written request to ETF if they wish to cancel health insurance coverage.

You may use the retained employer copy of this form to report the end of employer contributions to the employee's health insurance premium by completing **Part C** and resubmitting the form to ETF.

Employer: Keep a copy of this form for your records and make a copy for your employee.



Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)

The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020 (TTY: 1-800-947-3529)

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Pennsylvania Dutch: Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzsch, kannsch du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-533-5020 (TTY: 1-800-947-3529).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529).