



# Local 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**  
**LOCAL HEALTH INSURANCE ADMINISTRATION MANUAL**

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**PREFACE**

The *Local Health Insurance Administration Manual* (ET-1144) is intended to be a reference source to aid your administration of, and participation in, the Wisconsin Public Employer Group Health Insurance program. Its contents are based on state statute, administrative code, and group health contract language and it contains 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*. 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 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 if 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 number is (608) 264-7900.

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**.

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**101 Introduction**

The Wisconsin Public Employer 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-2128) 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 applications and arrange payroll deductions;
- Submit 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 contractual interpretation questions to ETF;

- Respond to health plan questions and audits in a timely manner; and
- 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-2128).
- 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  
PO Box 7931  
Madison WI 53707-7931

Local (Madison) 608-266-3285  
Toll Free 1-877-533-5020

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 Employer Withdrawal from the Group Health Insurance Program

Employer participation in the Group Health Insurance program is optional. Wisconsin statutes permit (Wis. Stat. §40.51(7)) an employer to withdraw from the program effective the end of any calendar year by submitting a *Resolution to Withdraw from Wisconsin Public Employers' Group Health Insurance Program* (ET-1318) to ETF by the preceding October 1 if the employer has participated for a full calendar year. Failure to execute the resolution by October 1 requires ETF's approval of the withdrawal.

Following an employer's withdrawal from the program, any employee eligible for coverage as a result of the employer's previous participation will lose eligibility for coverage. This includes Wisconsin Retirement System annuitants (retirees) and continuants (any employee or dependent of an employee who previously continued coverage). Coverage terminates on December 31 of that year.

Employers withdrawing from the Group Health Insurance program may not reapply for participation in the program for three years. ETF may impose enrollment restrictions on the employer appropriate to preserve the integrity of the program should the employer reapply for participation in the program after three years. Enrollment restrictions may also be imposed if ETF terminates the employer's participation in the program because the employer fails to maintain the minimum participation level of eligible employees or otherwise violates the terms of the contract.

## 107 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.

## 108 Administrative Offices

<b>MADISON</b>	
<b>Office:</b>	Department of Employee Trust Funds 801 W. Badger Road Madison WI 53702
<b>Mailing Address:</b>	PO Box 7931 Madison WI 53707-7931
<b>Telephone:</b>	Employers: (608) 264-7900 Employees: 1-877-533-5020 (toll free) (608) 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 Appleton WI 54912 1-866-333-2757 (toll free) <a href="http://www.navitus.com">www.navitus.com</a>	

## 109 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>	ET-2128
<i>Wisconsin Public Employers Standard and SMP Plan</i>	ET-2131
<i>Group Health Insurance Application</i>	ET-2301
<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 Public Employers 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) and 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.

Employers can choose to offer the traditional Uniform Benefits, or Uniform Benefits with an upfront deductible on medical services that is available at a lower premium rate. (Refer to subchapter 204.)

**202 Standard Plan**

The Standard Plan is a self-insured plan that pools the combined claims experience of all participating local governments. The classic Standard Plan is a fee for service indemnity plan. That is, employees enrolled in the Standard Plan can see any provider of their choice and are not restricted to specific providers, as in HMOs.

Employers can choose either the Classic Standard Plan or the Standard Preferred Provider Plan (PPP) option, which is available at a lower premium rate. (Refer to subchapter 204.) The PPP option allows participants to see any 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 an alternate health plan as designated in the current *It's Your Choice* booklet (ET-2128) as qualified, i.e., meeting minimum provider availability requirements. SMP subscribers must select an affiliated clinic to manage their health care and are subject to some health care provider limitations.

## 204 Program Options

Effective January 1, 2005, employers participating in the Group Health Insurance program can select from several different program options. Employers must select one option for all eligible employees, annuitants (retirees), and continuants and may not split its group between the options.

- Traditional HMO option paired with the Classic Standard Plan. Employers participating in the Group Health Insurance program prior to January 1, 2005, are enrolled in this option unless they have filed a resolution selecting a different option. Under this program option, participants select from:
  - HMOs that administer traditional Uniform Benefits
  - Classic Standard Plan with a deductible and coinsurance (participant pays percentage of costs) on major medical services only, such as durable medical equipment, physical/speech/occupational therapy, medical services and supplies, and cardiac rehabilitation
  - SMP, where applicable, with a deductible and coinsurance on major medical services only
- Traditional HMO option paired with the Standard PPP. Under this program option, participants select from:
  - HMOs that administer traditional Uniform Benefits
  - Standard PPP for which the benefit level (i.e., upfront deductible and coinsurance) depends on whether the services are from an in-network provider or an out-of-network provider
  - SMP, where applicable, with a deductible and coinsurance on major medical services only
- Deductible HMO option paired with the Deductible Standard Plan. Under this program option, participants select from:
  - HMOs that administer the Uniform Benefits with an upfront deductible on all medical services
  - Deductible Standard Plan with an upfront deductible and coinsurance on all medical services
  - SMP, where applicable, with an upfront deductible on all medical services

- Deductible HMO option paired with the Deductible Standard PPP. Under this program option, participants select from:
  - HMOs that administer the Uniform Benefits with an upfront deductible on all medical services
  - Deductible Standard PPP for which the benefit level (i.e., upfront deductible and coinsurance) depends on whether the services are from an in-network provider or an out-of network provider
  - SMP, where applicable, with an upfront deductible on all medical services

Employers must file a new resolution by October 1 to enroll in a different program option with an effective date of January 1 of the following year. Refer to Chapter 5 for instructions for submitting monthly reports when changing program options. Employers interested in changing their program option should contact the Employer Communication Center at (608) 264-7900.

## **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, including local government employees and annuitants, 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 108 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-2128) 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 will be 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 that plans will pay benefits are described in the *It’s Your Choice* booklet (ET-2128). Questions about COB can also be directed to health plans.

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**CHAPTER 3 — ELIGIBILITY, INITIAL ENROLLMENT AND  
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**301 Coverage Eligibility**

All employees, including part-time employees, participating in the Wisconsin Retirement System (WRS) are eligible for group health insurance and must be offered coverage if the employer elects to provide coverage under the Wisconsin Public Employers Group Health Insurance program. This includes:

- Active employees participating in the WRS.
- Retired employees receiving an annuity from the WRS (including a lump sum or disability annuity) who were participants in the employer's preceding group health insurance plan.
- Insured employees terminating employment after age 55 (age 50 for protective category employees) having 20 years of WRS creditable service who defer the annuity. Insured employees who terminate employment (for reasons other than gross misconduct) and fail to meet the above age and service requirements, must be offered continuation coverage. (Refer to Chapter 7.)
- Rehired annuitants that elect to return to active WRS coverage.

**302 Employer Premium Rate Contributions**

The *It's Your Choice* booklet (ET-2128) lists the monthly insurance premium for each health plan. The effective date of the employer contribution shall not be later than the first of the month following the completion of six months service with the employer under

WRS. Employers determine the amount they will contribute towards the premium under one of the following methods:

- A. 105% Contribution Method: The employer contribution toward the premium for any eligible employee will be between 50% and 105% of the least costly qualified health plan within the service area of the employer (but will not exceed the total premium for the selected plan). This dollar amount remains unchanged regardless of the health plan chosen by the employee. The employer contribution may be reduced to a minimum of 25% of the least costly qualified health plan for employees who are appointed to work less than half-time (1,044 hours).
- B. Tiered Contribution Method: A Three-Tier health insurance premium option is available. Each health plan is assigned to one of three tiers based on the relative efficiency with which it provides benefits and quality of care. Health plans providing the most cost effective, high-quality care as determined by ETF are assigned to Tier 1, moderately cost-effective plans to Tier 2, and the least cost-effective to Tier 3. The minimum employer contribution amount under the tiered contribution method is the same as the 105% contribution method (50% of the lowest cost plan in the employers service area for full-time employees and 25% for less than half-time employees). However, employers participating in a tiered contribution method are not limited to the maximum contribution of 105% of the premium of the lowest cost plan provided all of the following apply:
- The employer contribution toward employee health insurance premium is based upon the tier into which each available health plan is placed by the Group Insurance Board.
  - The employee required contribution to the health insurance premium for single coverage is the same dollar amount for all health plans in the same tier, regardless of the total premium. The employee required contribution to the health insurance premium for family coverage is the same dollar amount for all health plans in the same tier, regardless of the total premium.
  - The employee required contribution to the health insurance premium for a health plan classified in a higher cost tier, as compared to a health plan in the next lowest cost tier, increases by at least \$20 per month for single coverage and \$50 per month for family coverage.

Example: Assume there are only three health plans in the service area of the employer and all are qualified. One plan falls into each tier. The single and family premiums are as shown in the following table:

<b>Plan Name</b>	<b>Tier Placement</b>	<b>Total Single Premium</b>	<b>Total Family Premium</b>
Plan A	1	\$400.00	\$900.00
Plan B	2	\$440.00	\$1,000.00
Plan C	3	\$950.00	\$2,000.00

As all health plans are qualified, Plan A is the least costly qualified health plan. The minimum employer contribution for all health plans is shown in the table below:

**Minimum Employer Contribution Share**

	Full-time Employees	Part-time Employees
Single Coverage	\$200.00 (\$400 x 50%)	\$100.00 (\$400 x 25%)
Family Coverage	\$450.00 (\$900 x 50%)	\$225.00 (\$900 x 25%)

Under the 105% contribution method, the maximum employer share is 105% of the least costly qualified health plan within the service area of the employer, and it cannot exceed the total premium for the selected health plan. The maximum employer contribution for single coverage is \$420 (\$400 x 105%) and family coverage is \$945 (\$900 x 105%). The minimum employee contribution can be determined by subtracting the maximum employer contribution from the total premium. The table below summarizes the maximum employer and minimum employee contribution under the 105% contribution method for each health plan in this example:

**105% Contribution Method  
Maximum Employer / Minimum Employee Contribution**

Plan Name	Single Coverage			Family Coverage		
	Total Premium	Maximum Employer Share	Minimum Employee Share	Total Premium	Maximum Employer Share	Minimum Employee Share
Plan A	\$400.00	\$400.00	\$0	\$900.00	\$900.00	\$0
Plan B	\$440.00	\$420.00	\$20.00	\$1,000.00	\$945.00	\$55.00
Plan C	\$950.00	\$420.00	\$530.00	\$2,000.00	\$945.00	\$1,055.00

Under the tiered contribution method, the minimum employee contribution is a set dollar amount as described earlier in this subchapter. The table below summarizes the maximum employer and minimum employee contribution under the tiered contribution method for each plan in this example:

**Tiered Contribution Method  
Maximum Employer / Minimum Employee Contribution**

Plan Name	Tier	Single Coverage			Family Coverage		
		Total Premium	Maximum Employer Share	Minimum Employee Share	Total Premium	Maximum Employer Share	Minimum Employee Share
Plan A	1	\$400.00	\$400.00	\$0	\$900.00	\$900.00	\$0
Plan B	2	\$440.00	\$420.00	\$20.00	\$1,000.00	\$950.00	\$50.00
Plan C	3	\$950.00	\$910.00	\$40.00	\$2,000.00	\$1,900.00	\$100.00

**303 Initial Enrollment and Effective Dates**

Employers should immediately upon hire provide newly eligible employees with the *It's Your Choice* booklet (ET-2128) and the *Group Health Insurance Application* (ET-2301). All eligible employees must submit a completed application, even those who do not wish to enroll (Refer to subchapter 304).

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

- A. Within 30 days of their date of hire. Coverage is effective the first day of the month which occurs on or after the date the application is received by the employer; or
- B. Prior to the date the employee becomes eligible for the employer 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.

Coverage effective dates for teachers (employment category 10) are based on the dates WRS employment begins and the date a completed application is received by the employer. Health insurance coverage is effective the first of the month in which WRS employment begins if the application is received on, or prior to, the first of that month. For applications received after the first of the month in which WRS employment begins, coverage is effective the first of the following month.

Example: A teacher is hired (signs a contract) on June 27 and begins employment on August 29 (WRS begin date). In the event the employer receives the completed application on or prior to August 1, the coverage effective date is August 1. Should the employer receive the completed application after August 1 and on or prior to September 1, the coverage effective date is September 1.

**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 305 for other enrollment opportunities.)**

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

Employers have the option, when both spouses are employed by the same employer and both are eligible for coverage, of offering the following:

- A. Both employees may elect single coverage.
- B. One employee may elect family coverage.
- C. One employee may carry family coverage while the spouse has single coverage, if permitted by the employer.
- D. Both employees may carry family coverage with the employer, if permitted by the employer.

### 304 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) 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 305.

Employers are prohibited from providing payments to employees who decline coverage under this program.

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

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 without waiting periods for pre-existing conditions.

B. Change in Coverage: 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) to their employer during the special 30-day enrollment period along with documentation of the loss of other coverage, or the employer contribution ending. Coverage will be effective on the date the other coverage ends or 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 birth, adoption, placement for adoption, or marriage. Coverage is effective on the date of birth, adoption, placement for adoption, or marriage if an application is submitted within 30 days of a marriage or 60 days of the birth, adoption, or placement for adoption.

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

### 306 **Completing the *Group Health Insurance Application* (ET-2301)**

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-2128) and *Group Health Insurance Application* (ET-2301). 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. Retain the employer copy of the application and submit the remaining plies to ETF.

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 number given to employers by the Social Security Administration, beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- b. Name of Employer
- c. Program Option Code - identifies the program selected. (Refer to subchapter 1105.)
- d. Surcharge Code - identifies the surcharge amount, if any. (Refer to subchapter 1107.)
- e. Group Number - the first digit is the number 7, followed by the four-digit segment of the EIN (e.g., **79999**).
- f. Enrollment Type code - identifies the reason for submitting an application. (Refer to subchapter 1104.)

- g. Employee Type code - enter "06". (Refer to subchapter 1103.)
- h. Coverage Type Code - identifies the type of coverage selected. (Refer to subchapter 1102.)
- i. Carrier Suffix - identifies the health plan, or carrier, selected. This must match the name of the plan selected by the employee.
- j. Standard Plan Waiting Period - identifies for whom the 180 day waiting period applies. Leave this field blank if there is no waiting period. (Refer to subchapter 1106.)
- k. Participant County Code - the county of the subscriber's place of residence. (Refer to subchapter 1101.)
- l. Physician County Code - the county location of the subscriber's selected physician or clinic. (Refer to subchapter 1101.)
- m. Previous Service - Complete Information - check the appropriate response for each question.
- 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 subchapter 303.)
- 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. Refer to subchapter 108 for the mailing address.
2. Carrier Advance Copy - send immediately to the health plan.
3. Employer Copy - retain for your records.

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**Chapter 3 – Eligibility, Initial Enrollment and Coverage Information**

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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.

**NOTE: When an employer initially joins the Group Health Insurance program, the *Initial Offering Group Health Insurance Application* (ET-2343) is used for enrollment. This application is not used after the initial offering. After the initial offering, employees are required to complete *Group Health Insurance Applications* (ET-2301).**

**307 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)		Group No. _____ Subscriber No. _____							
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) _____											
<b>A. REASON FOR SUBMITTING APPLICATION</b>											
<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: _____							
<small>* 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.</small>											
<b>B. COVERAGE DESIRED</b> <input type="checkbox"/> Single (Applicant Only) <input type="checkbox"/> Family (Applicant, Eligible Spouse, Eligible Children)											
Last Name	First	Middle	Maiden	Birthdate MO DAY YR	Sex M/F	Social Security Number	Rel. Code	Student Status	SELECTED PHYSICIAN OR CLINIC. Indicate "NONE" if electing standard coverage.		
Applicant									Name (Last, First)	County	
Spouse											
Dependent Children											
<small>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.</small>											
<b>C. OTHER COVERAGE</b> — 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): _____											
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 ( )			
<b>EMPLOYER COMPLETES AREA BELOW</b> 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 ( )					

### 308 Identification (ID) Cards

Subscribers will receive an ID card from the health plan for use when obtaining medical services and an 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-2128).

### 309 Coverage During Leave of Absence

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 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.
- Employer contributions toward premium payment are at the discretion of the employer.
- 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 that labor organization ceases, whichever occurs first.
- Employees continuing coverage while on LOA are not required to complete a *Group Health Insurance Application* (ET-2301) 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.
- The employee may change level of coverage only if a special enrollment opportunity (e.g., marriage, birth, etc.) occurs during the LOA. (Refer to subchapter 305 for information about other enrollment opportunities.)
- Employees moving to a different county during an LOA may change health plans.
- 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.

### **310 Coverage During Layoff**

**A. Employee Continuing Coverage During Temporary Layoff**

The following apply to employees continuing health insurance coverage during a layoff:

- Coverage may be continued for up to 36 months while an employee is on layoff status.
- Employer contributions toward premium payment are at the discretion of the employer.
- 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.
- Employees on layoff status are reported along with active employees. Any payments received from employees on layoff 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 in layoff status prior to the beginning of the designated Dual-Choice enrollment period.
- Employees continuing coverage while on layoff status are not required to complete a *Group Health Insurance Application* (ET-2301) upon return to work.

B. Employee on Layoff Allows Coverage to Lapse:

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* 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.

### 311 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 and must be received in advance of the coverage month.
- The employee must pay both the employee and employer share of premium due each month until the appeal is resolved.
- The employee must continue to be reported along with active employees on the employer's monthly reports to ETF. Any payments received from employees appealing a discharge should be made payable to the employer and included in the employer's monthly remittance to ETF.

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 employer premium shares paid by the employee during the course of the appeal process. The employer is not required to return the employer 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 the 36 months from the original termination date, which is 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 7 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  
LOCAL HEALTH INSURANCE ADMINISTRATION MANUAL

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

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- 409 *Health Insurance Information Change Form* (ET-2329)**
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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. The employee must be currently insured in the Wisconsin Public Employers Group Health Insurance program; and
2. The *Group Health Insurance Application* (ET-2301) must be received by the employer during the designated Dual-Choice Enrollment period.

C. Distribution of *It's Your Choice* booklets (ET-2128)

*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 leave of absence.

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 changes them to whatever health plan or coverage type is desired 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 they are switching from. 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 they are switching to. 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) 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 rescind becomes a cancellation.

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

When a health plan is no longer available for the upcoming year, subscribers enrolled in that plan must submit a *Group Health Insurance Application* (ET-2301) during the Dual-Choice Enrollment period to enroll in a new health plan. Subscribers are notified by letter from the departing health plan at the onset of Dual-Choice. Subscribers who do not submit an application 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) should be accepted after the 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) to the employer within 30 days after the move.

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 an upcoming 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* (ET-2329) indicating the residential address change. (Refer to Subchapter 408.)

## 407 Adding/Deleting Dependents

### A. Adding a Dependent.

A dependent may become eligible due to marriage, birth, adoption or placement for adoption, or regaining eligibility status. Submit documentation for additions due to adoption.

1. 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). 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.
2. A subscriber enrolled in family coverage must add a newly eligible dependent by submitting to the employer a *Health Insurance Information Change* (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.
3. A subscriber can add a previously ineligible dependent that 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*. The application or change form must be submitted within 30 days of the dependent regaining eligibility with coverage effective the date eligibility was regained.

### B. Deleting a Dependent.

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 7 for information on continuation and conversion coverage.)

1. 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* 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.**

2. A subscriber who no longer has eligible dependents must submit to the employer a completed *Group Health Insurance Application* 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 703 for information about divorce.)

#### **408 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. (A sample follows this subsection.)

- |          |  |
|----------|--|
| Employee | <ol style="list-style-type: none"><li>1. Complete Sections 1 through 5 of the form and return it to employer:<ul style="list-style-type: none"><li>• Section 1 must be completed.</li><li>• Section 2 must be completed <u>only</u> when the subscriber is reporting one or more of the following changes:<ul style="list-style-type: none"><li>- Name change</li><li>- Address change</li><li>- Home or daytime phone number change</li><li>- Adding the social security number for a dependent</li><li>- Changing the selected physician or clinic</li><li>- Updating information about other insurance coverage</li></ul></li><li>• Section 3 must be completed <u>only</u> when <b>adding</b> a dependent and documentation attached where specified.</li><li>• Section 4 must be completed <u>only</u> when <b>deleting</b> a dependent.</li><li>• Section 5 must be completed.</li></ul></li></ol> |
| Employer | <ol style="list-style-type: none"><li>2. Upon receipt of this form, verify that the subscriber sections are completed appropriately and supporting documentation is attached when indicated.</li><li>3. Complete the bottom section of the form ensuring codes entered are consistent with most recent forms filed:</li></ol>  |

- a. Employee Type - enter the appropriate code. (Refer to subchapter 1103.)
  - b. Coverage Code - the type of coverage selected. (Refer to subchapter 1102.)
  - c. Two-digit Carrier Suffix identifying the health plan (carrier) (carrier suffixes appear on *Monthly Coverage Reports*) in which the subscriber is enrolled.
  - 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 - identifies the program selected. (Refer to subchapter 1105.)
  - g. Surcharge Code - identifies the surcharge amount, if any. (Refer to subchapter 1107.)
  - 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-**9999-000**).
  - j. Five-digit Group Number - the first digit is the number 7, followed by the four-digit segment of the EIN (e.g., **79999**).
  - 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. (Refer to subchapter 303.)
  - q. Payroll Representative Signature acknowledging the employer received and audited the form.
  - r. Telephone number of the employer representative who signed the form.
4. Retain the employer copy and give the employee copy to the employee.
  5. Immediately send the Carrier copy directly to the health plan and the ETF copy to ETF. This form does not have to accompany the regular monthly report(s) described in Chapter 5.

**409 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			Sex	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  Legal Ward Relationship Ends  
*\*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			Sex	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 ( )		

#### 410 Changing from Active to Annuitant Coverage

Retiring insured employees are eligible to continue health coverage under any of the following conditions: (Refer to Chapter 8)

- Employee receives a retirement (monthly or lump sum), 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 a retiring employee qualifies for health insurance coverage and the employer continues to pay all or part of the monthly health insurance premium, for example, through conversion of unused sick leave, the retiring employee is considered an Employer-Paid Annuitant. Refer to Chapter 6 for information on monthly reporting requirements for Employer-Paid Annuitants.

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*. Refer to Subchapter 503 for instructions on completing *the Monthly Deletions Report* and Subchapter 505 on completing the *Monthly Coverage Report*.

#### 411 Voluntarily Canceling Coverage

A subscriber can voluntarily cancel coverage at any time by submitting a *Group Health Insurance Application* (ET-2301) 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 coverage, which is described in Chapter 7.

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

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

SITUATION	FORM DUE DATE	EFFECTIVE DATE OF CHANGE
DUAL-CHOICE	Application due during the annual Dual-Choice Enrollment period as described in Subchapter 401.	January 1 of the following year.

SITUATION	FORM DUE DATE	EFFECTIVE DATE OF CHANGE
MARITAL STATUS CHANGE	Application (if changing from family to single or single to family coverage) or change form (if no change in coverage) due within 30 days after marriage, or 60 days of the divorce, or being widowed. 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 or notification is received, 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 7 on continuing coverage in divorce and surviving spouse situations.</li> </ul>
ADDING A DEPENDENT	Application (if changing from single to family or family to single coverage) or change form (if no change in coverage) due within 60 days of date of birth, adoption or placement for adoption. Documentation of adoption or placement for adoption must be provided.	Date of birth or date child placed for adoption.
MOVE TO ANOTHER COUNTY	Application due within 30 days of subscriber's relocation to another county.	First of the month following employer's receipt of application. 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.
VOLUNTARY CHANGE TO SINGLE COVERAGE	Application due within 30 days of change.	Effective first of the month following change if no eligible dependents exist; otherwise, the first of the month following employer's receipt of the application.
CHANGE TO FAMILY COVERAGE	If first becoming eligible for family coverage, or if already eligible for family coverage but single coverage is in effect, application 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.	<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>

<b>SITUATION</b>	<b>FORM DUE DATE</b>	<b>EFFECTIVE DATE OF CHANGE</b>
COVERAGE LAPSED DURING LEAVE OF ABSENCE	Application 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.
SINGLE CONTRACT IN EFFECT, NO ELIGIBLE DEPENDENTS – DEPENDENT REGAINS ELIGIBILITY DUE TO FULL-TIME STUDENT STATUS	Application 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 is unmarried.)	Family coverage is effective the date of enrollment (date classes begin) as full-time student if completed application is received within 30 days.
REINSTATEMENT AFTER COMPLETION OF ACTIVE MILITARY SERVICE	Application due within 30 days of return to employment. Must have had coverage prior to entry in military 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 re-employment. 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	Application 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	Application 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 expiration 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.

**Department of Employee Trust Funds**  
**LOCAL HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 5 — MONTHLY REPORTING – ACTIVE EMPLOYEES**

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

- 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***
- 506 Completing the *Health Insurance Summary***
- 507 Assembly of Health Insurance Reports**
- 508 Premium Remittance**
- 509 Credits**

The following subchapters apply only to those new employers being assessed a surcharge. Employers without an assessed surcharge (i.e., a Surcharge Code of S01) can disregard these subchapters.

- 510 New Employer Surcharge**
- 511 Surcharge Monthly Reports**

**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. For information on monthly reports for employer-paid annuitants, refer to Chapter 6.

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.**

The 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* - Used to summarize the additions, deletions and changes in coverage within each health plan for that coverage month. Use the form corresponding to the program option in which your employer is currently enrolled. (Refer to Subchapter 505 for a listing of form numbers for the various program options.)
- E. *Health Insurance Summary* - Used to summarize the results of the *Monthly Coverage Reports* for that coverage month. Use the summary form corresponding to the program option in which your employer is currently enrolled. (Refer to Subchapter 506 for a listing of form numbers for the various program options.)

Each report is discussed in detail in 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 given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- C. Five-digit Group # - The first digit of the group number 7, followed by the four-digits preceding the “-000” in your EIN (e.g., **79999**).
- D. Plan # - Two-digit code identifying the health plan (carrier). It is sometimes referred to as the carrier code or plan suffix code. (Refer to the *Monthly Coverage Report* for the plan codes.)
- E. Deduction Month - N/A - The 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):

1. Enrollment Type/Code -This code identifies the reason for submitting an application. (“Enrollment Type Code” field on the application.)
  2. Employee Type/Code - Enter the appropriate code. (Refer to Subchapter 1103.)
  3. Name Last, First, Middle I. - Employee name in alphabetical order by last name or in numeric order by social security number.
  4. Social Security No - List the employee’s social security number.
  5. 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.)
  6. (From) Plan Suffix, if applicable. The plan 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 plan suffix codes.)
  7. Effective Date - The month, day and year the coverage should be effective. (“Prospective Date of Coverage” field on the application.)
  8. 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.)
  9. 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 2005, and the effective date for the addition is March 1, 2005, enter March 2005 on one line, and April 2005 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.

**NOTE: When an employer initially joins the Wisconsin Public Employers Group Health Insurance program, all employees electing coverage must be listed on the *Monthly Additions Report*. In addition, when an employer changes program options, all employees electing coverage under the new program option by health plan must be listed on the *Monthly Additions Report* for the new program option and the *Monthly Deletions Report (ET-2612)* for the former program option.**

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>
48	John Beckett returned from military leave of absence and resumed coverage.

Monthly Additions Report Sample

GROUP HEALTH INSURANCE  
 MONTHLY ADDITIONS REPORT  
 Wis. Stat. § 40.06

Department of Employee Trust Funds  
 801 W. Badger Road  
 P.O. Box 7931  
 Madison, Wisconsin 53707-7931

Employer Name		Employer Number	Group #	Plan #	Deduction Month		Coverage Month			
Town of ABC		69-036-1234-000	71234	A4			Feb. 2005			
Enrollment Type/Code	EMPLOYEE Name Last, First, Middle I.	Social Security No.	Date of Hire or Re-hire	(From) Plan Suffix	Effective Date	Contract Type		PREMIUM ADJUSTMENT PREVIOUS MONTH(S)		
						Single	Family	Month	Amount	
02 06	Anderson, Terrance E. ↓	111-11-1111	11-8-04		12-1-04	02	02	Dec '04	1515.30	
48 06	Beckett, John J.	121-12-1212	7-24-95		2-1-05	01		Jan '05	2242.90	
03 06	Doe, Jane E. ↓	232-23-2323	11-29-04		12-1-04	01		Dec '04	628.20	
08 06	Johnson, Kelly A.	343-34-3434	3-15-04		2-1-05	01		Jan '05	919.40	
31 06	Rodgers, Andrea M.	454-45-4545	8-12-02		2-1-05	02	02			
40 06	Rodriguez, Maria A.	565-56-5656	2-11-02	39	1-1-05	02	02	Jan '05	2242.90	
41 06	Swanson, Katie L.	678-67-6786	4-26-99	30	2-1-05	02	02			
12 06	Williams, Sandra J. ↓	787-78-7878	7-15-02		11-1-04	01		Nov '04	628.20	
								Dec '04	628.20	
								Jan '05	919.40	
TOTAL ADDITION IN CONTRACTS							4	4		9,724.50

Post to Line 2 of the Monthly Coverage Report:

**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 7)	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)	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 – Employer elects <u>not</u> to pay any portion of continuing premium.	Coverage is continued without lapse upon retirement if an employee retires with an immediate annuity.*	<i>Employer Verification of Health Insurance Coverage.</i> (ET-4814)	ETF will coordinate coverage between active employment and annuitant status so that no lapse or duplication of coverage occurs.
Retirement – Employer pays some or all of continuing premium.	Coverage is continued without lapse. Employee becomes "Employer-Paid Annuitant".	<i>Group Health Insurance Transfer Report</i> (ET-1615)	Employee is deleted on Active employee coverage report and added to Employer-Paid Annuitant coverage report.
Transfer Between Spouses, or Health Plans	Coordinate transfer date so no duplication or lapse in coverage occurs.	<i>Group Health Insurance Application</i> (ET-2301)	Coordinate effective dates on the monthly reports with other spouse or health plan.
Divorced Spouse	End of the month in which divorce is entered or notification is received, whichever is later (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, or 50 if protective occupation, with at least 20 years of WRS creditable service and 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 EIN is the number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- C. Agency # - The first digit is the number 7, followed by the four-digits preceding the “-000” in your EIN (e.g., **79999**).
- D. Group/Carrier # - Two-digit code identifying the health plan (carrier). It is sometimes referred to as the carrier code or plan suffix code. (Refer to *Monthly Coverage Report*.)
- E. Deduction Month - N/A – The 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:
  1. Enrollment Type/Code - The code identifies the reason for the deletion. (Refer to Subchapter 1104.)
  2. Employee Type/Code - Enter the appropriate code. (Refer to Subchapter 1103.)
  3. Name (Last, First, Middle I) - Employee name in alphabetical order by last name or in numeric order by social security number.
  4. Social Security No - List the employee’s social security number.
  5. Birthdate - The month, day and year of the employee’s date of birth.
  6. (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.
  7. 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.).
  8. Effective Date - The month, day and year following the last day of coverage. It is generally the first of the month.
  9. 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.)

10. 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 2003 with a coverage end date of October 31, 2003. However, premiums are remitted in error until March 2005. A premium adjustment retroactive to January 2004 is allowed although adjustments for November and December 2003 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 2005, and the effective date for the deletion is March 1, 2005, enter March 2005 on a line, and April 2005 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.

**NOTE: When an employer changes program options, all employees that had elected coverage under the previous option must be listed on *the Monthly Deletions Report* and listed on the *Monthly Additions Report (ET-2610)* for the new program option.**

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> )

**Local Health Insurance**  
**Chapter 5 – Monthly Reporting-Active Employees**  
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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> )
48	Shelby Jackson begins a military leave of absence. ( <i>Premiums paid in advance can be refunded if employer receive a written request by the 20<sup>th</sup> of the month before the month to be refunded.</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

GROUP HEALTH INSURANCE MONTHLY DELETIONS REPORT Wis. Stats. § 40.06, 40.51 (7)										Enrollment Indicator		
Employer Name		Employer Number	Agency #	Group/Carrier #	Deduction Month		Coverage Month		PREMIUM ADJUSTMENT PREVIOUS MONTH(S)			
Town of ABC		69-036-1234-000	71234	A4			Feb. 2005					
Enrollment Type/Code	Name (Last, First, Middle I.)	Social Security No.	Birthdate	(To) Carrier Suffix	Event Date	Effective Date	Contract Type	Month(s)	Amount			
10 06	Andrews, Jeffrey W.	012-34-5678	7-10-64		12-31-04	1-1-05	01	Jan'05	(919.40)			
11 06	Goodman, Alan L. ↓	123-45-6789	9-15-52		11-12-04	12-1-04	02	Dec'04	(1515.30)			
09 06	Hughes, Valerie K.	234-56-7890	2-15-72		1-31-05	2-1-05	02					
48 06	Jackson, Shelby L.	345-67-8901	8-29-75		1-17-05	2-1-05	01					
40 06	Michaels, Robin E.	456-78-9012	6-30-61	22		1-1-05	02	Jan'05	(2242.90)			
03 06	Moore, Jeanne A.	567-89-0123	4-21-68		1-10-05	2-1-05	02					
31 06	Rodgers, Kenneth T.	678-90-1234	1-27-63			2-1-05	02					
50 06	Smith, Thomas M.	789-01-2345	2-2-50		1-21-05	2-1-05	02					
TOTAL DECREASE IN CONTRACTS										2	6	(6920.50)

(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 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).

**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**

<b>Activity/ Transaction</b>	<b>Effective Date</b>	<b>Adjustments/Refunds/Comments</b>
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.

<b>Activity/ Transaction</b>	<b>Effective Date</b>	<b>Adjustments/Refunds/Comments</b>
Divorce	First day of month following date divorce is entered or notification is received, whichever is later.	If divorced spouse was the sole dependent, employee's single coverage is effective on the first of the month following divorce decree or notification. 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).  Dependent 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.
Adding newborn dependent when single coverage is in force	Date of birth if application is received within 60 days of the birth.  OR First day of month following receipt of application.*	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.
*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.		

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

- A. Employer Name.
- B. EIN - EIN is the number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- C. Agency No - Leave this field blank.
- D. Group No - The first digit is the number 7, followed by the four-digits preceding the "-000" in your EIN (e.g., **79999**).
- E. Carrier Suffix - Two-digit code identifying the health plan (carrier). It is sometimes referred to as the carrier code or plan suffix code. (Refer to the *Monthly Coverage Report* for plan codes.)
- F. Deduction Month - N/A – Employers may use for internal purposes.

- G. Coverage Month - The month and year for which coverage is being reported.
- H. List employee last names--in alphabetical or social security number order--for which coverage is changing and complete the following information:
1. Enrollment Type - This code identifies the reason for the deletion. ("Enrollment Type Code" field on the application.)
  2. Employee Type - Enter the appropriate code. (Refer to Subchapter 1103.)
  3. Name Last, First, Middle I - Employee name in alphabetical order by 1st name or in numeric order by social security number.
  4. Social Security No - List the employee's social security number.
  5. Effective Date of Change - The month, day and year the change in coverage is effective.
  6. 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.)
  7. 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 - 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 2005, and the effective date for the coverage change is March 1, 2005, enter March 2005 on one line, and April 2005 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 2005 rates for Standard Plan: Balance of State:

\$2,242.90 Family

- 919.40 Single  
\$1,323.50 Adjustment

- I. 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>

Monthly Changes Report Sample

GROUP HEALTH INSURANCE  
 MONTHLY CHANGES REPORT  
 Wis. Stat. § 40.06

Department of Employee Trust Funds  
 801 W. Badger Road  
 P.O. Box 7931  
 Madison, Wisconsin 53707-7931

Enrollment Type	Employee Type	Name Last, First, Middle I.	Social Security No.	Effective Date of Change	TYPE OF CONTRACT												Deduction Month	Coverage Month			
					FROM						TO										
					Regular Plan			Medicare Supplement			Regular Plan			Medicare Supplemental			PREMIUM ADJUSTMENT PREVIOUS MONTH(S)				
					Single	Family	Grad Single	Grad Family	Single Med.	2 Med. Elig.	1 Med. Elig.	Single	Family	Grad Single	Grad Family	Single Med.	2 Med. Elig.	1 Med. Elig.	Month	Amount	
		Town of ABC	EIN 1234-000	Agency No. 71234	Group No. A4	Carrier Suffix													Feb 2005		
45	06	Daniels, Edward L.	987-65-4321	2-1-05	02							01							Dec '04	887.10	
66	06	Hernandez, Rosalie ↓	876-54-3210	12-1-04									02						Jan '05	1323.50	
43	06	Knot, Tyler R.	765-43-2109	1-16-05	01								02								
44	06	Miller, George E.	654-32-1098	2-1-05	02							01							Dec '04	(887.10)	
44	06	Taylor, Sarah A. ↓	543-21-0987	12-1-04	02								01						Jan '05	(1323.50)	
43	06	Thompson, Rochelle L	432-10-9876	1-1-05	01								02						Jan '05	1323.50	
TOTAL CHANGES (Post to Monthly Coverage Report: Decreases to Line 5, increases to Line 4)					3	3							3	3							1323.50
					(LINE 5 - DECREASE)						(LINE 4 - INCREASE)										

## 505 Completing the *Monthly Coverage Report*

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.

**NOTE: This section applies to employers who do not have a surcharge (i.e., Surcharge Code is S01). Employers that have a surcharge (i.e., Surcharge Code is S02 – S22) should refer to Subchapter 511 for information about completing the *Monthly Coverage Report*.**

### **MONTHLY COVERAGE REPORT FORM NUMBERS – ACTIVE EMPLOYEES\***

Program Option Code	Program Option Description	Form Number
P02	Traditional HMO/Classic Standard Plan	ET-1630
P03	Traditional HMO/Standard PPP	ET-1643
P04	Deductible HMO/Deductible Standard Plan	ET-1647
P05	Deductible HMO/Deductible Standard PPP	ET-1648

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 number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- B. Deduction Month - N/A - 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 first digit is the number 7, followed by the four-digits preceding the “-000” in your EIN (e.g., **79999**).
- G. **Line 1, Contracts in Effect Last Month** - Number brought forward from Line 6 of the previous month’s *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* 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 a 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,** The total employee share of the premiums.
- R. **Line B,** The total employer share of the premiums.
- S. **Line C,** The 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: Balance of State. 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 2005 rates for Standard Plan: Balance of State, the premium adjustment would be calculated by taking the difference between the single premium and the family premium.

\$2,242.90 Family  
- 919.40 Single  
**\$1,323.50 Total Adjustment**

2. The *Monthly Coverage Report* requires a breakdown of the employer and employee share of any premium adjustment.

In this example, the employer pays 80% of the health insurance premium, with the employee paying the remaining 20%. To determine the employee/employer breakdown, multiply the total premium adjustment obtained in Step 1 by the corresponding percentage:

Employer Share:     \$1,323.50 x 80% = \$1,058.80  
Employee Share:    \$1,323.50 x 20% = \$264.70

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*.

\$ 264.70 Employee Share Adjustment  
+1,058.80 Employer Share Adjustment  
**\$1,323.50 Total Adjustment**

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. Check the box indicating whether the Tiering or 105% method is used for determining the employer contribution share (Refer to Subchapter 302).
- X. 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.

Monthly Coverage Report Sample

Employee Trust Funds Group Health Insurance  <b>WPE TRADITIONAL HMO/CLASSIC STANDARD PLAN PGM OPT P02 &amp; SRCHG S01</b> <b>2005 MONTHLY COVERAGE REPORT</b>	Employer No. (EIN) 69-036- <b>1234-000</b>	Deduction Month 	Coverage Month <b>Feb 2005</b>	Suffix <b>A4</b>
Employer Name <b>Town of ABC</b>		Group No. <b>71234</b>		
		Single Contracts	Family Contracts	
1. Contracts in Effect Last Month:		<b>3</b>	<b>11</b>	
2. Additions Report: (+)	The circled parts of the form may vary, depending on the form number used.	<b>4</b>	<b>4</b>	
3. Deletions Report: (-)		<b>(2)</b>	<b>(6)</b>	
4. Changes Report: "To" (+)		<b>3</b>	<b>3</b>	
5. Changes Report "From": (-)		<b>(3)</b>	<b>(3)</b>	
6. Contracts in Effect This Month:		<b>5</b>	<b>9</b>	
7. Plan	Suffix			
Standard – Dane	.A1	979.40		2392.80
Standard – Milwaukee	.A2	1060.70		2596.10
Standard – Waukesha	.A3	1060.70		2596.10
Standard – Wisconsin	.A4	919.40		2242.90
State Maintenance Plan (SMP)	.A5	644.40		1545.10
CompcareBlue Southeast	.11	519.70		1280.80
CompcareBlue Northwest	.13	520.80		1283.50
CompcareBlue Northeast	.14	500.40		1232.60
Dean Health Plan	.15	367.40		900.10
CompcareBlue – Aurora/Family	.16	479.60		1180.60
Humana – Eastern	.21	534.00		1316.60
Humana – Western	.22	575.40		1420.10
GHC - Eau Claire	.30	547.70		1350.80
GHC - South Central	.35	378.50		927.80
Gundersen Lutheran	.37	505.40		1245.10
Atrium Health Plan	.39	577.60		1425.50
Unity – Community	.40	459.80		1131.10
Prevea Health Plan	.47	478.70		1178.30
Health Tradition	.55	503.50		1240.30
Medical Associates HMO	.63	431.60		1060.50
MercyCare Health Plan	.64	387.10		949.30
Valley Health Plan	.65	521.80		1292.80
Network – Fox Valley	.70	490.50		1207.80
Physicians Plus	.74	379.10		929.30
Unity - UW Health	.92	369.20		904.60
UnitedHealthcare	.94	419.20		1029.50
8. Subtotals (No. of Contracts x Premiums)		8a <b>4,597.00</b>		8b <b>20,186.10</b>
A. Employee Share =	<b>5,221.30</b>	**	(Line 8a + Line 8b)	
B. Employer Share =	<b>20,885.30</b>	**	9. Subtotal	<b>24,783.10</b>
C. Total* (Lines A + B) =	<b>26,106.60</b>	**	10. Adjustments	<b>1,323.50</b>
			(Line 9 + Line 10)	11. Grand Total*
				<b>26,106.60</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) <b>1/19/2005</b>	Prepared By <b>Betty Lou Payroll</b>	Telephone <b>715-123-4567</b>
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Check the type of employer contribution:  Tiering  105%

## 506 Completing the *Health Insurance Summary*

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.

**NOTE:** This section applies to employers who do not have a surcharge (i.e., Surcharge Code is S01). Employers that have a surcharge (i.e., Surcharge Code is S02 – S22) should refer to Subchapter 511 for information about completing the *Health Insurance Summary*.

### HEALTH INSURANCE SUMMARY FORM NUMBERS – ACTIVE EMPLOYEES

Program Option Code	Program Option Description	Form Number
P02	Traditional HMO/Classic Standard Plan	ET-1631
P03	Traditional HMO/Standard PPP	ET-1652
P04	Deductible HMO/Deductible Standard Plan	ET-1649
P05	Deductible HMO/Deductible Standard PPP	ET-1650

When completing the *Health Insurance Summary*, employers should first verify that they are utilizing the correct form (provided by ETF) for the program option in which they are enrolled. To complete the *Health Insurance Summary*, enter the following information:

- A. Employer Name.
- B. Employer No. (EIN) - The number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- 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. Grand Totals - The sum of the amounts calculated in the Subtotal Alt. Health and Subtotal Std. Health rows.
- I. Date (MM/DD/CCYY) - The date the report was completed.

Prepared By - The signature of the person who prepared the report.

- J. Telephone - The telephone number of the person who prepared the report.
- K. Submit this form along with the other monthly reports as described in Subchapter 507. Include a check for the amount shown in the Total column of the Grand Totals row - the total premium for all the health plans reported.

Following is a sample *Health Insurance Summary* completed based on the information from the sample *Monthly Coverage Report* in this chapter.

**Health Insurance Summary Sample**

Department of Employee Trust Funds  
 801 W. Badger Road, Madison, WI 53702-0011

**WPE TRADITIONAL HMO/CLASSIC STANDARD PLAN  
 PGM OPT 02 & SRCHG S01  
 HEALTH INSURANCE SUMMARY – 2005**

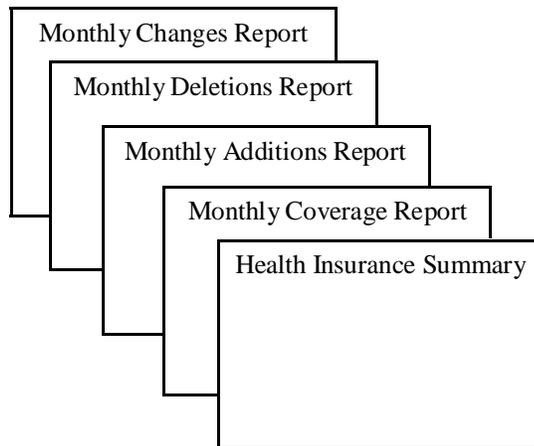
EMPLOYER NAME		EMPLOYER NO. (EIN)	COVERAGE MONTH	
Town of ABC		69-036-1234-000	Feb. 2005	
PLAN	SUFFIX NO.	EMPLOYEE SHARE	EMPLOYER SHARE	TOTAL
CompcareBlue Southeast	.11			
CompcareBlue Northwest	.13			
CompcareBlue Northeast	.14			
Dean Health Plan	.15			
CompcareBlue – Aurora/Family	.16			
Humana – Eastern	.21			
Humana – Western	.22	683.10	2,732.50	3,415.60
GHC - Eau Claire	.30	379.70	1,518.80	1,898.50
GHC - South Central	.35			
Gundersen Lutheran	.37			
Atrium Health Plan	.39	516.10	2,064.60	2,580.70
Unity-Community	.40			
Prevea Health Plan	.47			
Health Tradition	.55			
Medical Associates HMO	.63			
MercyCare Health Plan	.64			
	.65			
Network - Fox Valley	.70			
Physicians Plus	.74			
Unity - UW Health	.92			
UnitedHealthcare	.94			
<b>SUBTOTAL ALT. HEALTH</b>		<b>1,578.90</b>	<b>6,315.90</b>	<b>7,894.80</b>
Standard – Dane	.A1			
Standard – Milwaukee	.A2			
Standard – Waukesha	.A3			
Standard – Wisconsin	.A4	5,221.30	20,885.30	26,106.60
State Maintenance Plan (SMP)	.A5			
<b>SUBTOTAL STD. HEALTH</b>		<b>5,221.30</b>	<b>20,885.30</b>	<b>26,106.60</b>
<b>GRAND TOTALS</b>		<b>6,800.20</b>	<b>27,201.20</b>	<b>34,001.40</b>

The circled parts of the form may vary,  
 depending on the form number used.

Date (MM/DD/CCYY) 1/19/2005	Prepared By Betty Lou Payroll	Telephone 715-123-4567
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## 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 the check attached to the front.
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) 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 your check stub or a photocopy of the check stapled behind it.
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:
  - a. *Monthly Additions Report*

- b. *Monthly Deletions Report*
- c. *Monthly Changes Report.*

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

## 508 Premium Remittance

- A. 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.)**

- 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. Whenever 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.

EXAMPLE: The March 2005 (coverage month) report is due in ETF on Monday, February 21, 2005, which is the next working day following the 20th.

- 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% for each day from the due date to the date 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

- 1. 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

2. 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. The exception is when the employee terminates employment and the employer continues to make premium payments, in which case, retroactive credits will be limited to two months of premiums paid.

## **510 New Employer Surcharge**

Effective January 1, 2005, employers with 100 or more WRS active employees who join the Group Health Insurance program must go through the underwriting process. In the event the Group Insurance Board's actuary determines the employer's risk to be detrimental to the existing risk pool of the program, a surcharge will be assessed for a minimum of the first 18 months and a maximum of the first 27 months of participation in the program. The surcharge is a per-contract, per-month charge added to the premium amount for the program option selected. ETF assigns a surcharge code identifying the assessed amount.

This surcharge applies to all contracts with the exception of the Medicare – Family 2 coverage. The employer is responsible for communicating the assessed surcharge amount to its employees, annuitants (retirees), and continuants.

## **511 Surcharge Monthly Reports**

Each month, employers must report to ETF the total number of health insurance contracts by health plan for their employees. Monthly reports must be accurate and complete to ensure correct premium remittance and proper coverage.

Monthly reports 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 for instructions on completing the report.)
- B. *Monthly Deletions Report* (ET-2612) used to report contracts terminating from each health plan. (Refer to Subchapter 503 for instructions on completing the report.)
- 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 for instructions on completing the report.)

NOTE: You must account for the surcharge amount when calculating adjustments to the premium.

EXAMPLE: An employee changes from single to family coverage under the Standard Plan: Balance of State. The employer has a surcharge amount of \$40 for a single contract and \$100 for a family contract. An adjustment for the difference in premiums is required—enter in the Premium Adjustment column of the *Monthly Changes Reports*.

- 1. Using the 2005 rates for Standard Plan: Balance of State, the premium adjustment is calculated by taking the difference between the single premium and the family premium.

$\$2,342.90$  Family (\$2,242.90 premium + \$100 surcharge)  
 $- \underline{959.40}$  Single (\$919.40 premium + \$40 surcharge)  
**\$1,383.50 Total Adjustment**

- 2. The *Monthly Coverage Report* requires a breakdown of the employer and employee share of any Premium Adjustment and must account for any surcharge.

In this example, the employer pays 80% of the health insurance premium, with the employee paying the remaining 20%. To determine the employee/employer breakdown, multiply the Total Premium Adjustment obtained in Step 1 by the corresponding percentage:

Employer share:  $\$1,383.50 \times 80\% = \$1,106.80$   
Employee share:  $\$1,383.50 \times 20\% = \$276.70$

- 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*.

$\$ 276.70$  Employee Share Adjustment  
 $\underline{+1,106.80}$  Employer Share Adjustment  
**\$1,383.50 Total Adjustment**

- D. *Monthly Coverage Report*: ETF supplies employers with *Monthly Coverage Reports*

listing the premium amount (including the assessed surcharge, if any). (Refer to Subchapter 505 when completing the *Monthly Coverage Report*.)

- E. *Health Insurance Summary*: ETF supplies employers with *Health Insurance Summaries* for the designated Surcharge Code. (Refer to Subchapter 506 when completing the *Health Insurance Summary* and include the surcharge when indicating employer and employee contribution shares.)

Assemble the reports as described in Subchapter 507 and submit the premium remittance and reports as described in Subchapter 508.

**Department of Employee Trust Funds**  
**LOCAL HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 6 — MONTHLY REPORTING – EMPLOYER-PAID ANNUITANTS**

- 601** Definition of Employer-Paid Annuitant
- 602** Overview of Monthly Reports
- 603** Completing the *Group Health Insurance Transfer Report* (ET-1615)
- 604** Completing the *Monthly Coverage Report*
- 605** Completing the *Health Insurance Summary*
- 606** Employer-Paid Annuitant – Medicare Reporting Requirements
- 607** Subscriber Ceases to be an Employer-Paid Annuitant

If you already use the automated system for monthly reporting, please refer to Chapter 12 – “Automated Monthly Reporting” instructions in place of this chapter.

**601 Definition of Employer-Paid Annuitant**

A retiree is an Employer-Paid Annuitant when the employee’s last employer before retirement pays **all** or **part** of the monthly health premium. The employee must be eligible to continue health insurance coverage at retirement based on requirements defined in Subchapter 801. Retirees paying all of the premium—the employer contributes nothing to the premium payment—are not Employer-Paid Annuitants. (Refer to Chapter 8.) After the employer reports these annuitants paying all the premiums on the deletions report, ETF processing moves the employee to annuitant status with the agency.

The portion of the premium, if any, paid by the annuitant must be remitted directly to the employer by the retiree. It is the employer’s responsibility to collect the balance due from the retiree.

**602 Overview of Monthly Reports**

Each month, the employer must report to ETF the total number of health insurance contracts by health plan for Employer-Paid Annuitants. **These reports are separate from those for active employees.** The employer is required to remit the full premium to ETF for the current coverage month. It is extremely important that the monthly reporting forms are completed accurately to ensure accurate premium remittance. **For information on monthly reports for active employees, refer to Chapter 5.**

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 getting prescriptions filled.**

The monthly reports for Employer-Paid Annuitants consist of the following:

- A. *Group Health Insurance Transfer Report* (ET-1615) - Used to report employees changing from active coverage to Employer-Paid Annuitant coverage. (Refer to Subchapter 603 for instructions on completing the report.) Also used to report Employer-Paid Annuitants who cease to have employer-paid premium contributions. (Refer to Subchapter 607.)
- B. *Monthly Additions Report* (ET-2610) - Used to report new Employer-Paid Annuitant contracts for each health plan. (Refer to Subchapter 502 for instructions on completing the report.)
- C. *Monthly Deletions Report* (ET-2612) - Used to report Employer-Paid Annuitants terminating from each health plan. (Refer to Subchapter 503 for instructions on completing the report.)
- D. *Monthly Changes Report* (ET-2614) - Used to report changes in Employer-Paid Annuitant coverage—single to family and family to single—within each health plan. (Refer to Subchapter 504 for instructions on completing the report.)
- E. *Monthly Coverage Report* - Used to summarize the Employer-Paid Annuitant additions, deletions and changes in coverage within each health plan for that coverage month. Use the form corresponding to the program option in which your employer is currently enrolled. (Refer to Subchapter 604 for a listing of form numbers for the various program options.)
- F. *Health Insurance Summary* - Used to summarize the results of the *Monthly Coverage Reports* for that coverage month. Use the summary form corresponding to the program option in which your employer is currently enrolled. (Refer to Subchapter 605 for a listing of form numbers for the various program options.)

Assemble the reports as described in Subchapter 507 and submit the premium remittance and reports as described in Subchapter 508.

### **603 Completing the *Group Health Insurance Transfer Report* (ET-1615)**

The employer must complete a *Group Health Insurance Transfer Report* (ET-1615) to report an employee changing from active coverage to Employer-Paid Annuitant coverage. The form changes the health insurance status of the active subscriber to retiree status as an employer paid annuitant. THE ENTIRE FORM MUST BE COMPLETED. To complete the form:

- A. Employee Name - (Last, First, Middle Initial)
- B. Social Security Number - The social security number of the employee/annuitant.
- C. Sex (M/F) - The gender of the employee/annuitant.

- D. Birthdate - The date of birth of the employee/annuitant.
- E. Carrier Name - The name of the health plan in which the employee is enrolled.
- F. Carrier Suffix - The two-digit code identifying the health plan (carrier) being reported. It is sometimes referred to as the carrier code or plan suffix code and appears on the *Monthly Coverage Report*.
- G. Transfer To.
1. Employer Name.
  2. Employer Number - The EIN is the number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
  3. Five-digit Group Number - The first digit of the group number is 7, followed by the four-digits preceding the “-000” in your EIN (e.g., **79999**).
  4. Enrollment Type code “50”; identifies the subscriber as having applied for retirement benefits.
  5. Employee Type code “09”; denotes a Local Employer-Paid Annuitant.
  6. Coverage Code - Coverage code identifying single or family coverage and indicating Medicare enrollment if applicable. (Refer to Subchapter 1102.)
  7. Event Date - The date (MM/DD/CCYY) the Employer-Paid Annuitant status begins.
  8. Coverage Report Month - Indicate the monthly report on which the annuitant will be reported as an Employer-Paid Annuitant **addition**.
  9. Coverage Begin Date - Enter the date that the Employer-Paid Annuitant coverage will **begin** as an Employer-Paid Annuitant for this employee. It is important to coordinate the coverage begin date (as it appears on the additions report) with the coverage end date (as it appears on the deletions report) to ensure that a lapse of coverage does not occur.
- H. Transfer From.
1. Employer Name.
  2. Employer Number - The employer identification number (EIN) is the number given to employers by the Social Security Administration, beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
  3. Five-digit Group Number - The first digit of the group number is 7,

followed by the four-digits preceding the “-000” in your EIN (e.g., **79999**).

4. Employee Type code “06”; denotes a local employee.
  5. Coverage Code - Coverage code identifying single or family coverage. (Refer to Subchapter 1102.)
  6. Coverage Report Month - Indicate the monthly report on which the annuitant will be reported as an active employee deletion.
  7. Coverage End Date - The date through which premiums have been paid at the time the employee retires and ceases to be covered as an active employee.
- I. Payroll Representative Signature - This signature acknowledges the employer completed the form.
  - J. Date Submitted (MM/DD/CCYY) - The date on which the form was completed.
  - K. Telephone Number - The telephone number of the person that completed the form.
  - L. The *Group Health Insurance Transfer Report* has a carrier ply, an ETF ply, and a ply for the employer’s files. The carrier ply should be sent immediately to the health plan, and the ETF ply should be sent immediately to ETF.

**NOTE: It is necessary for the employer to report an active employee changing to Employer-Paid Annuitant status by reporting the employee on the *Monthly Deletions Report* (ET-2612) for the active employees and on the *Monthly Additions Report* (ET-2610) for Employer-Paid Annuitants.**

## Group Health Insurance Transfer Report

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

### GROUP HEALTH INSURANCE TRANSFER REPORT

Wis. Stat. § 40.06

This form is to be completed by the employer when a state employee transfers to another state agency/group or when a local employee leaves active employment and starts employer paid annuitant status. Transactions such as changing HMOs or changing from single to family coverage require a new *Health Insurance Application* (ET-2301) and should not be submitted on this form.

Employee Name (Last, First, Middle Initial)		
Social Security Number	Sex (M/F)	Birthdate (MM/DD/CCYY)
Carrier Name		Carrier Suffix

#### TRANSFER TO

Employer Name		Employer Number <b>69-036-</b>	Group Number
Enrollment Type	Employee Type	Coverage Code	
Event Date	Coverage Report Month	Coverage Begin Date	

#### TRANSFER FROM

Employer Name		Employer Number <b>69-036-</b>	Group Number
Employee Type		Coverage Code	
Coverage Report Month		Coverage End Date	

Payroll Representative Signature	
Date Submitted (MM/DD/CCYY)	Telephone Number

Original - ETF White Copy - Carrier Pink Copy - Employer
--

## 604 Completing the *Monthly Coverage Report*

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 Employer-Paid Annuitants are enrolled.

**NOTE: This section applies to employers who do not have a surcharge (i.e., Surcharge Code is S01). Employers that have a surcharge (i.e., Surcharge Code is S02 – S22) should refer to Subchapter 511 for information about completing the *Monthly Coverage Report*.**

### MONTHLY COVERAGE REPORT FORM NUMBERS - EMPLOYER-PAID ANNUITANTS

Program Option Code	Program Option Description	Form Number
P02	Traditional HMO/Classic Standard Plan	ET-1657
P03	Traditional HMO/Standard PPP	ET-1658
P04	Deductible HMO/Deductible Standard Plan	ET-1645
P05	Deductible HMO/Deductible Standard PPP	N/A*

\*The form number was not available at the time of the printing of this manual.

When completing the *Monthly Coverage Report*, employers should first verify that they are utilizing the correct form for the program option that they are enrolled. To complete the *Monthly Coverage Report*, enter the following information:

- A. Employer No. (EIN) - EIN is the number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- B. Deduction Month - N/A – 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 first digit of the group number is 7, followed by the four-digits preceding the “-000” in your EIN (e.g., **79999**).
- G. **Line 1, Contracts in Effect Last Month**. Brought forward from Line 6 of the previous month’s *Monthly Coverage Report* for Employer-Paid Annuitants.
- H. **Line 2, Additions Report: (+)** - Post the total counts from the *Monthly Additions Report* (ET-2610) for Employer-Paid Annuitants in the appropriate contract type column. If there are no additions to report, put a dash (-) in the field.
- I. **Line 3, Deletions Report: (-)** - Post in parentheses the total counts from the *Monthly Deletions Report* (ET-2612) for Employer-Paid Annuitants in the

appropriate contract type column. If there are no deletions to report, put a dash (-) in the field.

- J. **Line 4, Changes Report: "To" (+)** - Post the total counts from the "To" column of the *Monthly Changes Report* (ET-2614) for Employer-Paid Annuitants in the appropriate contract type column. If there are no "To" changes to report, put a dash (-) in the field.
- K. **Line 5, Changes Report: "From" (-)** - Post in parentheses the total counts from the "From" column of the *Monthly Changes Report* for Employer-Paid Annuitants in the appropriate contract type column. If there are no "From" changes to report, put a dash (-) in the field.
- L. **Line 6, Contracts in Effect This Month** - Calculate the total number of each contract type by adding the numbers in Lines 1 through 5 of the column, except those numbers in parentheses. Subtract the numbers in parentheses (deletions). Post the total in the appropriate contract type column.

**NOTE: Employer-Paid Annuitants must provide notice when they and/or their covered dependents become eligible for Medicare. When notified of Medicare eligibility, the employer should report the change in coverage type on the *Monthly Changes Report*. (Refer to Subchapter 606.)**

- M. **Line 8, Subtotals (No. of Contracts x Premiums)** - Calculate the subtotal for each contract type by multiplying the number of contracts on Line 6 by the premium rate for the health plan being reported.
- N. **Line 9, Subtotal** - Enter 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 a 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, remembering to subtract Line 10 from Line 9 if Line 10 is a negative amount shown in parentheses.
- Q. **Line A.** Enter the total Employer-Paid Annuitant share of the premiums.
- R. **Line B.** Enter the total employer share of the premiums.

- S. **Line C.** Enter the 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 for the health plan on the *Health Insurance Summary* as described in Subchapter 605.

**NOTE: For reporting purposes, adjustments must be broken down between the Employer-Paid Annuitant and employer share.**

EXAMPLE: An Employer-Paid Annuitant changes from Family to Family 1 Medicare Eligible contract under the Standard Plan: Balance of State. An adjustment for the difference in premiums is required, which would be shown in the "Premium Adjustment" column of the *Monthly Changes Report* for Employer-Paid Annuitants.

1. Using the 2005 rates for Standard Plan: Balance of State, the premium adjustment would be calculated by taking the difference between the Family premium and the Family 1 Medicare Eligible premium.

\$2,242.90 Family  
- 1,244.00 Family 1 Medicare Eligible  
**\$ 998.90 Total Adjustment**

2. The *Monthly Coverage Report* requires a breakdown of the employer and Employer-Paid annuitant share of any premium adjustment. In this example, the employer pays 85% of the health insurance premium and the Employer-Paid Annuitant pays the remaining 15%. To determine the Employer-Paid Annuitant/employer breakdown, multiply the total premium adjustment obtained in Step 1 by the corresponding percentage:

Employer Share:  $\$998.90 \times 85\% = \$849.07$   
Employer-Paid Annuitant Share:  $\$998.90 \times 15\% = \$149.83$

3. Double-check your adjustment figures for accuracy by adding the Employer-Paid Annuitant share adjustment and the employer share adjustment; the sum should match the adjustment on the *Monthly Changes Report*.

\$ 149.83 Employer-Paid Annuitant Share Adjustment  
+ 849.07 Employer Share Adjustment  
**\$ 998.90 Total Adjustment**

4. Make the necessary adjustment to the employee (Employer-Paid Annuitant) and employer share amounts for the appropriate health plan on the *Monthly Coverage Report*.

- T. Date (MM/DD/CCYY) - The date on which 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. Check the box indicating whether the Tiering or 105% method is used for determining the employer contribution share (Refer to Subchapter 302).
- X. Attach the monthly additions, deletions and changes reports for the health plan along with any supporting documentation. Refer to Subchapter 507 for information regarding the assembly of the reports upon completion.

Following is a sample *Monthly Coverage Report*.

**Monthly Coverage Report**

Employee Trust Funds  
 Group Health Insurance

**WPE ANNUITANTS TRADITIONAL HMO/  
 CLASSIC STANDARD PLAN  
 PGM OPT P02 & SRCHG S01  
 2005 MONTHLY COVERAGE REPORT**

Employer No. (EIN) 69-036-	Deduction Month	Coverage Month	Suffix
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Employer Name	Group No.
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Single Contracts	Family Contracts	Single Med. Eligible	Family 2 Med. Eligible	Family 1 Med. Eligible
------------------	------------------	----------------------	------------------------	------------------------

1. Contracts in Effect Last Month:					
2. Additions Report: (+)					
3. Deletions Report: (-)					
4. Changes Report: "To" (+)					
5. Changes Report "From": (-)					

*The circled parts of the form may vary, depending on the form number used.*

6. Contracts in Effect This Month:						
7. Plan	Suffix					
Standard - Dane	.A1	979.40	2392.80	368.40	703.20	1303.90
Standard - Milwaukee	.A2	1060.70	2596.10	368.40	703.20	1385.30
Standard - Waukesha	.A3	1060.70	2596.10	368.40	703.20	1385.30
Standard - Wisconsin	.A4	919.40	2242.90	368.40	703.20	1244.00
State Maintenance Plan (SMP)	.A5	644.40	1545.10	N/A	N/A	N/A
CompcareBlue Southeast	.11	519.70	1280.80	415.30	818.30	919.10
CompcareBlue Northwest	.13	520.80	1283.50	416.20	820.10	921.10
CompcareBlue Northeast	.14	500.40	1232.60	399.90	787.50	884.40
Dean Health Plan	.15	367.40	900.10	293.50	574.70	645.00
CompcareBlue - Aurora/Family	.16	479.60	1180.60	383.30	754.30	847.00
Humana - Eastern	.21	534.00	1316.60	426.80	841.30	944.90
Humana - Western	.22	575.40	1420.10	459.90	907.50	1019.40
GHC - Eau Claire	.30	547.70	1350.80	437.70	863.10	969.50
GHC - South Central	.35	378.50	927.80	302.40	592.50	665.00
Gundersen Lutheran	.37	505.40	1245.10	308.20	604.10	801.30
Atrium Health Plan	.39	577.60	1425.50	461.70	911.10	1023.40
Unity - Community	.40	459.80	1131.10	367.40	722.50	811.30
Prevea Health Plan	.47	478.70	1178.30	382.50	752.70	845.30
Health Tradition	.55	503.50	1240.30	402.40	792.50	890.00
Medical Associates HMO	.63	431.60	1060.50	305.80	599.30	725.10
MercyCare Health Plan	.64	387.10	949.30	309.30	606.30	680.50
Valley Health Plan	.65	521.80	1292.80	416.90	825.90	928.10
Network - Fox Valley	.70	490.50	1207.80	392.00	771.70	866.60
Physicians Plus	.74	379.10	929.30	302.90	593.50	666.10
Unity - UW Health	.92	369.20	904.60	294.90	577.50	648.20
UnitedHealthcare	.94	419.20	1029.50	334.90	657.50	738.20

8. Subtotals (No. of Contracts x Premiums)	8a	8b	8c	8d	8e
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A. Employee Share =	**	(8a + 8b + 8c + 8d + 8e)
B. Employer Share =	**	9. Subtotal
C. Total* (Lines A + B) =	**	10. Adjustments
		(Line 9 + Line 10)
		11. Grand Total*

\* 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)	Prepared By	Telephone
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## 605 Completing the *Health Insurance Summary*

The *Health Insurance Summary* is used to report total premium by employee (Employer-Paid Annuitant) share and employer share, for each health plan summarizing the results of the *Monthly Coverage Reports* for each coverage month.

**NOTE: This section applies to employers who do not have a surcharge (i.e., Surcharge Code is S01). Employers that have a surcharge (i.e., Surcharge Code is S02 – S22) should refer to Subchapter 511 for information about completing the *Health Insurance Summary*.**

### **HEALTH INSURANCE SUMMARY FORM NUMBERS – EMPLOYER-PAID ANNUITANTS\***

Program Option Code	Program Option Description	Form Number
P02	Traditional HMO/Classic Standard Plan	ET-1655
P03	Traditional HMO/Standard PPP	ET-1644
P04	Deductible HMO/Deductible Standard Plan	ET-1653
P05	Deductible HMO/Deductible Standard PPP	ET-1654

When completing the *Health Insurance Summary*, employers should first verify that they are utilizing the correct form for the program option that they are enrolled. To complete the *Health Insurance Summary*, enter the following information:

- A. Employer Name.
- B. Employer No. (EIN) - EIN is the number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
- C. Coverage Month - The month and year for which coverage is being reported.
- D. Plan - For each health plan in which Employer-Paid Annuitants are enrolled, enter the amount of employee (Employer-Paid Annuitant) 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 (Employer-Paid Annuitant) 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 Standard Health - The sum of the amounts entered in each column for the Standard Plans and SMP.

- H. Grand Totals - The sum of the amounts calculated in the Subtotal Alt. Health and Subtotal Standard Health rows. Enter this amount, which is the total of all plans reported.
- I. Date (MM/DD/CCYY) - The date on which the report was completed.
- J. Prepared By - The signature of the person who prepared the report.
- K. Telephone - The telephone number of the person who prepared the report.
- L. Submit this form along with the other monthly reports as described in Subchapter 507. Include a check for the amount shown in the “Total” column of the “Grand Totals” row - the total premium for all the health plans reported.

Following is a sample *Health Insurance Summary*.

**Health Insurance Summary**

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

**WPE ANNUITANTS TRADITIONAL HMO/CLASSIC STANDARD PLAN  
 PGM OPT 02 & SRCHG S01  
 HEALTH INSURANCE SUMMARY – 2005**

EMPLOYER NAME	EMPLOYER NO. (EIN) 69-036-	COVERAGE MONTH
<b>PLAN</b>	<b>SUFFIX NO.</b>	<b>EMPLOYEE SHARE      EMPLOYER SHARE      TOTAL</b>
CompcareBlue Southeast	.11	
CompcareBlue Northwest	.13	
CompcareBlue Northeast	.14	
Dean Health Plan	.15	
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	
Prevea Health Systems	.47	
Health Tradition	.55	
Medical Associates HMO	.63	
MercyCare Health Plan	.64	
Valley Health Plan	.65	
Network - Fox Valley	.70	
Physicians Plus	.74	
Unity - UW Health	.92	
UnitedHealthcare	.94	
<b>SUBTOTAL ALT. HEALTH</b>		
Standard – Dane	.A1	
Standard – Milwaukee	.A2	
Standard – Waukesha	.A3	
Standard – Wisconsin	.A4	
State Maintenance Plan (SMP)	.A5	
<b>SUBTOTAL STANDARD HEALTH</b>		
<b>GRAND TOTAL</b>		

*The circled parts of the form may vary,  
 depending on the form number used.*

Date (MM/DD/CCYY)	Prepared By	Telephone
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## 606 Employer-Paid Annuitant – Medicare Reporting Requirements

The Employer-Paid Annuitant and insured dependents must enroll in both parts of Medicare (Part A Hospital and Part B Medical) when first eligible.

- A. *Medicare Eligibility Statement* (ET-4307) is used to inform ETF of the Medicare effective dates. ETF mails the form to the Employer-Paid Annuitant for completion after qualifying birthday. The form is returned to ETF showing the Medicare effective dates. ETF mails the form to the employer to complete the employer section and submit with the *Monthly Coverage Report*. Return the top (ETF) copy of the *Medicare Eligibility Statement* to ETF. (Refer to Subchapter 802).
- B. Medicare Reporting Requirements
  - 1. Reduce the health insurance premium on the Medicare effective date, which is the date the retiree, or a dependent, is enrolled for both parts of Medicare.
  - 2. Report the change on the *Monthly Changes Report* (ET-2614) prepared for Employer-Paid Annuitants, attaching the carrier copy of the completed *Medicare Eligibility Statement*. (Refer to Subchapter 504.) Attach the *Monthly Changes Report* – indicating premium adjustments if necessary – to the applicable plan's *Monthly Coverage Report* for Employer-Paid Annuitants.

## 607 Subscriber Ceases to be an Employer-Paid Annuitant

- A. When the employer no longer remits any part of the health insurance premium, the subscriber ceases to be an Employer-Paid Annuitant. The employer must submit a *Group Health Insurance Transfer Report* (ET-1615) to ETF at least two months prior to the date coverage will end as an Employer-Paid Annuitant. This allows sufficient time for ETF to set up the premium payment method. ETF will deduct the premium from the monthly annuity payment unless the premium amount is greater than that monthly annuity payment. In the event the annuity is insufficient to cover the premium cost, the premium payment becomes the subscriber's responsibility.
- B. The employer completes a *Group Health Insurance Transfer Report* notifying ETF the subscriber is no longer an Employer-Paid Annuitant. (Refer to Subchapter 603 for instructions on completing the report.) Return the top two plies of the report to ETF. The third ply is for employer records.
- C. Complete the *Monthly Deletions Report* (ET-2612) and *Monthly Coverage Report* for the designated health plan indicating that coverage for the Employer-Paid Annuitant has been deleted.
- D. The subscriber can pay premiums in one of the following ways: (Refer to Subchapter 804.)

1. ETF will deduct premiums from a monthly retirement or disability annuity, if sufficient to cover the premiums,
2. Directly to the insurance carrier by the annuitant if the annuity is not sufficient; or
3. By converted Wisconsin Public Employers Group Life Insurance. (Refer to Subchapter 804.)

**Department of Employee Trust Funds**  
**LOCAL HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 7 – COBRA, CONTINUATION and CONVERSION**

<b>701</b>	<b>Overview of COBRA, Continuation and Conversion</b>
<b>702</b>	<b>Persons Eligible for Continuation (Qualified Beneficiaries)</b>
<b>703</b>	<b>Employee/Qualified Beneficiary Responsibilities</b>
<b>704</b>	<b>Employer Responsibilities</b>
<b>705</b>	<b>Notice Requirement Illustration Chart</b>
<b>706</b>	<b>Continuation Coverage Information</b>
<b>707</b>	<b>Instructions on Completing the <i>Continuation – Conversion Notice Form (ET-2311)</i></b>
<b>708</b>	<b>Sample <i>Continuation – Conversion Notice (ET-2311)</i></b>

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

Participants and their eligible dependents covered under the Wisconsin Public Employers 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 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 702. 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 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.

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

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 704 for employer responsibilities.)

- A. Employees must be offered continuation coverage if they lose eligibility because of the following events:
  - 1. Termination of employment (for reasons other than gross misconduct), including retirement. The exception is when an employee retires and submits, to their employer, an *Employer Verification of Health Insurance Coverage* (ET-4814) electing to take an immediate annuity and continue health insurance. (Refer to Chapter 8.)
  - 2. Transfer into non-eligible employment. For example, an employer’s protective category employees are covered under WRS as required by law, but their non-protective employees are not; the WRS covered employees also participate in the Group Health Insurance program. A protective employee transferring to a non-protective position at this employer would lose coverage under the Group Health Insurance program. That qualifying event makes the employee eligible for continuation.
  - 3. Completion of the maximum prepayment periods of 36 months while on a leave of absence or layoff (Refer to Subchapters 309 and 310).
- B. The spouse of an employee with family coverage in the Group Health Insurance program becomes a qualified beneficiary as a result of the following qualifying events:
  - 1. Death of spouse (employee); refer to Chapter 10 on Employee Death.
  - 2. Divorce. Coverage as a dependent spouse continues until the end of the month in which the divorce decree is entered or notification is given,

whichever is later. (Refer to Subchapter 703.)

3. Spouse (employee) loses coverage for reasons listed above in A.
- C. Each eligible dependent child of an employee with family coverage in the Group Health Insurance program becomes a qualified beneficiary as a result of the following qualifying events:
1. Death of parent (employee); refer to Chapter 10 on Employee Death.
  2. Dependent eligibility status ceases under the Group Health Insurance program. (Refer to the chart in Subchapter 705 for examples.)
  3. Parents become divorced resulting in loss of eligibility.
  4. Parent (employee) loses coverage for reasons listed above in A.
- D. An eligible dependent grandchild of an employee with family coverage in the 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 Group Health Insurance program becomes a qualified beneficiary upon loss of disabled status. Coverage terminates at the end of the month it is determined the disabled status ceases.

**NOTE: Voluntary cancellation does not create a continuation enrollment opportunity. For example, a voluntary change in coverage from a family plan to a single plan is not a qualifying event and dependents do not have the opportunity to elect continuation. The exception is when the voluntary cancellation is done in anticipation of a divorce, in which case the spouse and dependent children are eligible for continuation coverage when the divorce is final.**

### **703 Employee/Qualified Beneficiary Responsibilities**

- A. Employees and/or the qualified beneficiaries (Refer to Subchapter 702) are responsible for informing the employer of a qualifying event in which an employee and/or dependent loses eligibility for coverage under the 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. Once the employer receives notification of the divorce, the ex-spouse and any stepchildren are terminated from coverage effective the end of the month that notification is received. The ex-spouse and any stepchildren must then be given the right to continue coverage even if notice is given beyond 60 days following the divorce. In this situation, employers must check with ETF on the length of continuation coverage that is available.

- B. Qualified beneficiaries are responsible for the following when electing continuation or conversion coverage:
1. Submitting the *Continuation-Conversion Notice* (ET- 2311) and the *Group Health Insurance Application* (ET-2301) 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 Group Health Insurance program will end.
  2. Paying premium to the health plan when billed by the health plan.
  3. 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.

## 704 Employer Responsibilities

- A. **Within 14 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:
1. *Continuation-Conversion Notice* (ET-2311), with the employer sections completed as described in Subchapter 707.
  2. *Group Health Insurance Application* (ET-2301). This form is needed to enroll in continuation or conversion. However the employee does not need to complete the application continuing the coverage already in effect. The employee must still complete and return the *Continuation-Conversion Notice*.

**NOTE: Federal COBRA law requires a continuation notice be provided within the 14-day 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 707 for**

**information on providing notice.)**

- B. The employer is responsible for informing qualified beneficiaries of the following:
1. 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.**
  2. If electing continuation coverage, the health plan will bill the continuant(s) directly.
  3. If electing continuation coverage through a health plan 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 of 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 of the move, coverage is limited to the Standard Plan with a 180-day waiting period for pre-existing conditions.
- C. 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.

**705 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.	3/15/05	12/31/05	3/1/06	14 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	6/10/05	6/30/05	8/29/05	14 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Student Status Terminates for 20-Year Old Dependent	6/2/05	12/31/05	3/1/06	14 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
Divorce Decree is Entered	4/3/05	4/30/05	6/29/05	14 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer
Dependent Over Age 19 Loses Disabled Status	8/25/05	8/31/05	10/30/05	14 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice from employer
Dependent Marries	5/7/05	5/31/05	7/30/05	14 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	6/16/05	7/31/05	9/29/05	14 days after receipt of notice	The later of 60 days after coverage terminates, or 60 days of receipt of notice by employer

## 706 Continuation Coverage Information

- A. The benefits under continuation coverage are identical to those provided to active employees.
- B. The health plan chosen must be the one that was in effect at the time of termination of coverage. If the qualified beneficiary does 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. Participants enrolled on continuation coverage (continuants) are allowed to change health plans during the annual Dual-Choice Enrollment period or upon a residential move out of the county.
- C. Continuation coverage may be in effect for up to 36 months. However, continuation coverage may be terminated early and cannot be reinstated for any of the following reasons:
  1. The premium for continuation coverage is not paid when due.
  2. 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.)
  3. A spouse is divorced from a covered employee and subsequently remarries and is covered through their new spouse's group health plan.

4. The date the former employer no longer offers group health insurance coverage.

**NOTE: If an employer terminates participation in the Group Health Insurance program, coverage for any continuants of that employer group also terminates.**

5. Qualified beneficiary voluntarily cancels continuation coverage.
- D. Continuants may elect to convert to individual coverage (conversion) 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.

## 707 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 following information:
  1. In the box located in the upper right hand corner, list:
    - Employee Social Security Number
    - Employee Name (Last, First)
    - Employee's Birthdate (MM/DD/CCYY)
    - Group # - The first digit is the number 7, followed by the four-digits preceding the "-000" in your EIN (e.g., **79999**).
  2. 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* (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* (ET-2301) instead of the *Health Information Change* form.
  3. Identify the relationship of the qualified beneficiary(ies) to the employee by checking the following boxes that apply:
    - Employee

- Spouse/Former Spouse
- 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.**

4. 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 it blank.

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

- Terminating Employee - The date the group health insurance premiums are currently paid through.
- Divorced Spouse - The end of the month in which notice of the divorce is given.
- Dependent Child - The date will be the earlier of the following:
  - a. The end of the month in which the child marries.
  - b. 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.
    - Ceases to be dependent for support and maintenance.
- Dependent Grandchild - The end of the month in which the child (grandchild's parent) turns 18.
- 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:

- Signature of the person completing the employer portions of the notice
- Date (MM/DD/CCYY) the notice is given to the qualified beneficiary
- Employer name and mailing address
- 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 704.)

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.

## **708 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  
 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 <b>123-45-6789</b>	
Employee Name (Last, First) <b>Smith, Jonathon</b>	
Employee's Birthdate: (MM/DD/CCYY) <b>01/01/1960</b>	Group # <b>71234</b>

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

123 Apple St  Employee  
 Street and No.  
Anytown WI 59876  Spouse/Former Spouse Name \_\_\_\_\_  
 City State Zip Code  
 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 the 60-day notice period

2. Date applicant/qualified beneficiary's coverage ends: 7/31/2004

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: 7/17/2004

5. Date employer notified of occurrence in Item 3: 12/20/2004

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

7. Name of Health Plan Dean Health Plan Monthly Premium Rate: \$ 854.80

8. Completed By Betty Lou Payroll Date (MM/DD/CCYY) 12/22/2004 Employer Name and Mailing Address Town of XYZ Telephone (608) 987-6543  
123 Any St - Anytown, WI 51234

**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:	<b>608-264-7900</b>

**Department of Employee Trust Funds**  
**LOCAL HEALTH INSURANCE ADMINISTRATION MANUAL**

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**CHAPTER 8 — RETIREMENT, DISABILITY OR  
LONG-TERM DISABILITY INSURANCE**

- 801 Coverage – Requirements to Continue**
- 802 Medicare Enrollment**
- 803 Completing *Employer Verification of Health Insurance Coverage* (ET-4814)**
- 804 Annuitant Premium Payments**
- 805 Reporting a Retiring Employee Who Is Not an Employer-**
- 806 Paid Annuitant**
- 807 Canceling Coverage**

**801 Coverage – Requirements to Continue**

Coverage under the Wisconsin Public Employers 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 802.)

- 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.

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 by the date of their first annuity payment.

- 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 lapsed 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 filed with ETF by the date of their first annuity payment. ETF will notify the employer when a disability or LTDI benefit is approved. The employer will then need to delete from active coverage. (Refer to Chapter 6.) A completed *Employer Verification of Health Insurance Coverage* form

(ET-4814) is submitted to ETF at the time of the employee's retirement or application for disability or LTDI benefit. (Refer to Subchapter 803 for instructions on how to complete the form.)

- 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. A *Continuation – Conversion Notice* (ET-2311) is completed and submitted to ETF at the time of the employee's termination. (Refer to Subchapter 707 for instructions regarding this form.)

For additional information, see the *Group Health Insurance* brochure (ET-4112) for retired employees.

## 802 Medicare Enrollment

Active employees and their insured dependents eligible for coverage under the Federal Medicare program may defer enrollment under Medicare Part A (hospital) and Part B (medical) until the employee terminates employment or health insurance coverage as an active employee ceases.

Annuitants and insured dependents who are 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. Failure to enroll in Medicare at the next enrollment opportunity may result in termination of coverage in the Group Health Insurance program.

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

<i>Return form to the Department of Employee Trust Funds.</i>		Social Security Number
SUBSCRIBER NAME – <i>Annuitant, Surviving Spouse, or Continuant</i> (Last, First, Middle, Maiden)	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	Insurance Plan Name
ADDRESS (Street, City, State, Zip Code)		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.

- 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.

HEALTH  INSURANCE	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JOHN Q PUBLIC	SEX <b>SAMPLE</b> MALE
CLAIM NUMBER 000-00-0000-0	EFFECTIVE DATE
IS ENTITLED TO HOSPITAL (PART A) 7-1-95 MEDICAL (PART B) 7-1-95	
SIGN HERE → <u>John Q Public</u>	

NAMES	Social Security Claim Number	Birthdate (MM/DD/CCYY)	MEDICARE EFFECTIVE DATES <i>as shown on card</i>	
			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 <b>69-036-</b>	Group Number

### 803 Completing *Employer Verification of Health Insurance Coverage* (ET-4814)

An *Employer Verification of Health Insurance Coverage* must be submitted to ETF for each employee regardless of whether the employee plans to continue health coverage after retirement. The form is required, even when the employer is paying all or part of an annuitant's monthly health premium. An insured employee receives the form with the retirement application from ETF. The form is also required for a surviving spouse/dependent of a deceased insured employee or employer-paid annuitant. The employee or survivor completes the top portion of the form and submits to the employer.

Employer Instructions - Complete the Employer Section of the form reflecting the coverage as of the date employment terminates:

1. Check the appropriate box for coverage verification:
  - a. Coverage verified is in effect; or
  - b. Coverage verified is not yet in effect but employee has submitted a health insurance application to change coverage. (Advise employee to submit a *Group Health Insurance Application* (ET-2301) with the *Employer Verification of Health Insurance Coverage* form if coverage will change when coverage as an active employee ceases.)
2. Plan - The name of the health plan.
3. Five-digit Group Number - The first digit of the group number is 7, followed by the four-digits preceding the "-000" in your EIN (e.g., **79999**).
4. Coverage Type - Indicate Single or Family coverage.
5. Monthly Premium Rate - Enter the full monthly premium rate – TOTAL OF EMPLOYEE AND EMPLOYER CONTRIBUTIONS. Refer to the current *It's Your Choice* booklet (ET-2128).
6. Enter the month, day (the last day of the month) and year through which health insurance coverage is paid as an active employee.
7. Indicate whether premiums will be paid by the employer after termination: "Yes" or "No."
8. Name of Employer.
9. Employer Number - The number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
10. Date - Enter the current date.
11. Signature of Employer Representative - Signature of the employer representative completing the form.

12. Telephone Number - The telephone number of the employer representative who completed the form.

Return the top two plies to the employee. Keep the bottom ply for your records. The employee must submit the form to ETF after completing the employee portion. A sample of the *Employer Verification of Health Insurance Coverage* form appears at the end of this subchapter.

**Employer Verification of Health Insurance Coverage (ET-4814)**

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

**EMPLOYER VERIFICATION OF HEALTH INSURANCE COVERAGE**

**TO THE EMPLOYEE:** If you have Wisconsin Public Employers' Group Health Insurance coverage, and wish to continue this insurance after you retire, you must submit this form. If you do not submit this completed form, your health insurance coverage will cease.

Take this form to your employer for completion of the employer portion. Please review the coverage information reported by your employer for accuracy before returning this form. This form should reflect coverage as of the date your employment terminates.

If you have been on a leave of absence without pay and your health insurance has lapsed, you are eligible to reinstate insurance coverage if you take an "immediate" annuity (one that begins within 30 days after your termination date). Please contact the Department of Employee Trust Funds for a health insurance application and instructions.

Note: If you receive this form as a surviving spouse or dependent of a deceased insured employee, please complete this form by putting the deceased participant's name and Social Security number as the "Employee" and complete the identifying information for yourself in the "Spouse" section. Then take this form to the deceased participant's employer for completion and return it with your health insurance application.

I wish to continue my health insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please note that there currently are no re-enrollment opportunities for the Wisconsin Public Employers' Group Health Insurance Program.	
Date (MM/DD/CCYY)	Signature of Employee

<b>EMPLOYEE COMPLETE:</b>					Social Security Number
Name (Last, First, M.I.)					Birthdate (MM/DD/CCYY)
Address	Street and No.	City	State	Zip Code	Anticipated Termination Date
Spouse Name (Last, First, M.I.)			Birthdate (MM/DD/CCYY)		Social Security Number

**EMPLOYER COMPLETE:**

Please note that this is not an application. The employee must file a *Health Insurance Application* form (ET-2301) for any eligible coverage changes. CHECK ONE OF THE BOXES BELOW:

- A.  The coverage verified below is currently in effect. OR
- B.  The coverage verified below is not yet in effect. The employee has submitted an application for eligible coverage/plan changes.

Health insurance coverage for the above-named employee on the anticipated termination date:

Plan	Group Number
Coverage Type: <input type="checkbox"/> Single <input type="checkbox"/> Family	Monthly Premium Rate \$
Premiums will have been paid as an ACTIVE employee for coverage through what month and year? _____ (MM/DD/CCYY)	
Premiums will be paid through the employer after termination as an employer-paid annuitant: <input type="checkbox"/> Yes <input type="checkbox"/> No	
NOTE: If you have marked "yes" in this box, the employer must notify the Department of Employee Trust Funds when premiums will no longer be paid through the employer. Complete a <i>Group Health Insurance Transfer Report</i> (ET-1615). Instructions are in the <i>Local Health Insurance Administration Manual</i> (ET-1144).	

Name of Employer		Employer Number 69-036-
Date (MM/DD/CCYY)	Signature of Employer Representative	Telephone Number

EMPLOYER: Keep the bottom ply for your records.  
 EMPLOYEE: Submit the top two plies. A copy will be returned to you.

White Ply – ETF Copy  
 Pink Ply – Acknowledgment  
 Yellow Ply – Employer Copy

## 804 Annuitant Premium Payments

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

- A. Employer-Paid Annuitant--Premiums are paid to ETF by the employer when the employer pays any portion of the premium for the annuitant. (Refer to Chapter 6 for reporting employer-paid annuitant health coverage.)
- B. Annuity Deduction—Premiums are paid from a monthly retirement or disability annuity if the annuity is sufficient to cover the entire premium and no portion of the premium is being paid by the employer;
- 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 premium 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).

## 805 Reporting a Retiring Employee Who Is Not an Employer-Paid Annuitant

A retiring employee who qualifies to continue health insurance coverage is reported on the *Monthly Deletions Report* (ET-2612) and *Monthly Coverage Report* for active employees for that health plan. (Refer to Chapter 5 for instructions.) In this situation, an *Employer Verification of Health Insurance Coverage* form (ET-4814) must be submitted to ETF.

## 806 Canceling Coverage

At the time of retirement, health insurance can be canceled by indicating “No” on the *Employer Verification of Health Insurance Coverage* form (ET-4814) where asked if the employee wishes to continue health insurance. Following retirement, the insured annuitant must submit written notification to ETF to cancel coverage. Refer to the *It’s Your Choice* booklet (ET-2128) for more information.

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**LOCAL 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 the WRS annuity or health insurance benefits, if any. Eligibility for 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).

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 (if the new employer participates in the Wisconsin Public Employers Group Health Insurance program).

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 participating 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. ETF will assist the employer in determining when the employee should be added to active coverage on the monthly addition report. As premiums paid through the annuity are deducted two months in advance, insurance will be paid for two months beyond the annuity end date. 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, as the former annuitant is 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, Federal law (COBRA) provides that the employee has the right 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 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 they are 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) 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 a 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 as long as the former employer participates in the Wisconsin Public Employers Group Health Insurance program. 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 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.

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.

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

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

- A. 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.

OR

- B. Enroll as an employee and receive the employer contribution share toward premium. However, with this option, the right to continue coverage indefinitely as a surviving spouse is forfeited. Eligibility to continue coverage upon termination of employment due to retirement is dependent upon the spouse meeting the retirement eligibility requirements. (Refer to Chapter 8.) Should the retirement eligibility requirement not be met, the spouse may be eligible for continuation or conversion. (Refer to Chapter 7.)

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**CHAPTER 11 — CODES**

- 1101 County Codes**
- 1102 Coverage Codes**
- 1103 Employee Type Codes**
- 1104 Enrollment Type Codes**
- 1105 Program Option Codes**
- 1106 Standard Plan Waiting Period Codes**
- 1107 Surcharge Codes**

The following codes are required for completing the employer sections of forms used in the administration of the Wisconsin Public Employers 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	Marinette
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).
05	Medicare – Single	Employer-paid annuitant or Annuitant; Single coverage with Medicare.
06	Medicare – Family 1	Employer-paid annuitant or Annuitant; Family coverage and one person with Medicare.
07	Medicare – Family 2	Family coverage; subscriber and dependent both with Medicare.

### 1103 Employee Type Codes

Code	Employee Type	Description
06	Local	Eligible local government employee.
07	Annuitant	Retired employee who is eligible for health insurance.
08	Surviving Spouse/ Dependent	Currently insured subscriber dies while carrying family health insurance coverage.
09	Local Paid Annuitant	WRS annuitant whose former employer pays all or part of the monthly health insurance premiums.

### 1104 Enrollment Type Codes

Code	Used For:	Enrollment Type	Description	Used On:
01	Additions	Initial Offering	Employee whose employer is initially enrolling in the Group Health Insurance program.	New Employer Application (ET-2343) & Monthly Reports
02	Additions	Initial Enrollment	Employee is applying for health insurance for the first time since becoming an eligible employee.	Application (ET-2301) & Monthly Reports
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
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 same employer).	Application & Monthly Reports

<b>Code</b>	<b>Used For:</b>	<b>Enrollment Type</b>	<b>Description</b>	<b>Used On:</b>
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
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
48	Additions	Entered/Returned From Military LOA	Employee entered or returned from Military LOA.	Application & Monthly Reports
49	Additions	Entered/Returned From Family Medical Leave of Absence (FMLA)	Employee entered or returned from a FMLA.	Application & Monthly Reports
51	Additions	Transfer to Standard Plan		Application & Monthly Reports
53	Additions	Annuitant	Transfer from active employer group to annuitant group.	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
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
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.	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
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
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

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<b>Code</b>	<b>Used For:</b>	<b>Enrollment Type</b>	<b>Description</b>	<b>Used On:</b>
48	Deletions	Entered/Returned From Military LOA	Employee entered or returned from Military LOA.	Monthly Reports
49	Deletions	Entered/Returned From Family Medical Leave of Absence (FMLA)	Employee entered or returned from a FMLA.	Monthly Reports
50	Deletions	Retires	Employee retires.	Monthly Reports
51	Deletions	Transfer to Standard Plan		Application & Monthly Reports
53	Deletions	Employer Paid Annuitant	Transfer from active employer group to local employer paid annuitant group.	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	Insured participant enrolled in Medicare.	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).	Change Form (ET-2329)
66	Other	Premium Adjustment Only	To indicate a premium adjustment only.	Monthly Reports

### 1105 Program Option Codes

Code	Program Option Description
P02	Traditional HMO option paired with the Classic Standard Plan
P03	Traditional HMO option paired with the Standard PPP
P04	Deductible HMO option paired with the Deductible Standard Plan
P05	Deductible HMO option paired with the Deductible Standard PPP

### 1106 Standard Plan Waiting Period Codes

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

### 1107 Surcharge Codes

Code	Description
S01	No surcharge.
S02	Low risk surcharge applied during months 13 – 24 in health program.
S03	Moderate risk surcharge applied during months 13 – 24 in health program.
S04	High risk surcharge applied during months 13 – 24 in health program.
S05	Low risk surcharge applied during first 12 months in health program.
S06	Moderate risk surcharge applied during first 12 months in health program.
S07	High risk surcharge applied during first 12 months in health program.
S08	Low risk surcharge applied during months 10 – 21 in health program.
S09	Moderate risk surcharge applied during months 10 – 21 in health program.
S10	High risk surcharge applied during months 10 – 21 in health program.
S11	Low risk surcharge applied during first 9 months in health program.
S12	Moderate risk surcharge applied during first 9 months in health program.
S13	High risk surcharge applied during first 9 months in health program.
S14	Low risk surcharge applied during first 18 months in health program.
S15	Moderate risk surcharge applied during first 18 months in health program.
S16	High risk surcharge applied during first 18 months in health program.
S17	Low risk surcharge applied during months 16 – 27 in health program.
S18	Moderate risk surcharge applied during months 16 – 27 in health program.
S19	High risk surcharge applied during months 16 – 27 in health program.
S20	Low risk surcharge applied during first 15 months in health program.
S21	Moderate risk surcharge applied during first 15 months in health program.
S22	High risk surcharge applied during first 15 months in health program.

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**CHAPTER 12 — AUTOMATED MONTHLY REPORTING**

This chapter is for employers who have elected to 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 hopes to unveil 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, and also in contrast to the current reporting application, ETF will provide a full range of tech support for the new application. However, it must be noted that an updated application is still in the early design stage, the extent of the automation is unknown at this time, and the actual rollout date remains uncertain.

It is also possible that rising health care costs may lead to contractual or legislative changes to the health insurance program requiring new premium structures and reporting requirements beyond the functionality of the current application. With this in mind, ETF plans to issue annual update diskettes for the current application until a new reporting system is available or until health insurance reporting requirements outstrip the features of the current application. Consequently, ETF may not be able to provide updates to the current application in Plan Year 2006 or 2007 if a new reporting system is not available at that time. In the event ETF is unable to provide a replacement system before suspension of the current Automated Health Insurance Reporting Application, we will make every attempt to provide as much notice as possible to allow you time to develop an internal process.

ETF is excited to begin the challenge of review and redesign of the existing health process with an eye toward more efficient enrollment and simplified monthly premium reporting. ETF will continue to communicate the progress of any changes to the existing health process to all employers participating in the Group Health Insurance Program.

This 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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- 1208 Coverage Entry Screen for Employer-Paid Annuitants
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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 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 the Department of Employee Trust Funds 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 Registration Copies of Health Insurance Applications and the Carrier Copies of the Health Insurance Information Change and Transfer forms should be submitted to ETF as soon as possible prior to the anticipated effective date. 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. Employers who elect to utilize the Premium Payment Screen, will not need to submit a photocopy of the check or a check stub. Otherwise, include a photocopy of the check and check stub.
  2. Paper copies of the following Reports until ETF begins electronic reporting to the carriers:  
NOTE: Samples and explanations of these Reports are included in Subchapter 1216.
    - a. The "Local Health Insurance - Individual Carriers" generated for each carrier for whom contracts have been identified.
    - b. The "Local Health Insurance – Adjustments." The Carrier plies of the Health Insurance Applications should be attached to the Adjustment Report(s).
    - c. The "Local 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 "Local 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 "Local Health Insurance - Grand Totals."  
NOTE: If you are also reporting Contracts for Employer Paid Annuitants, you

will also need to generate the following Reports:

- f. The "Local Employer Paid Annuitant Health Insurance - Individual Carriers" generated for each Carrier for whom Contracts have been identified.
  - g. The "Local Employer Paid Annuitant Health Insurance – Adjustments." The carrier plies of the Health Insurance Applications should be attached to the Adjustment Report(s).
  - h. The "Local Employer Paid Annuitant Health Insurance - Alternate Totals." gives the total employee/employer share and the adjustment amount of the premiums collected for all HMO Contracts reported.
  - i. The "Local Employer Paid Annuitant 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.
  - j. The "Local Employer Paid Annuitant 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) 266-0728. 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) 266-2737.

## 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 Local Employer, the following Icons will automatically appear once this Application has been installed: The Local Coverage Icon, the Local Annuitant Coverage Icon, and the Premium Payment Icon.



*ETF Automated Monthly Health Insurance Reporting System.*

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

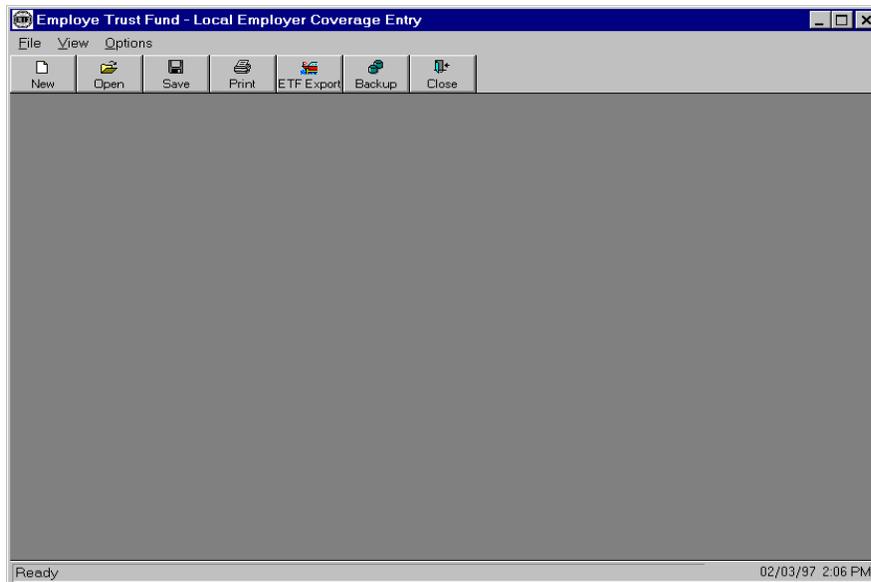
If you do not report Local Employer Paid Annuitant Contracts, this icon can be deleted. To delete this icon, single click on the Local Annuitant Coverage icon (which will highlight the icon). Press **Delete**. A window will pop up asking if you are sure that you want to delete the item. Press **Enter**.

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

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

## 1206 Main Screen

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 Local Coverage Icon the following **Main Screen** will appear.



*The Main Menu for Local 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

*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:**

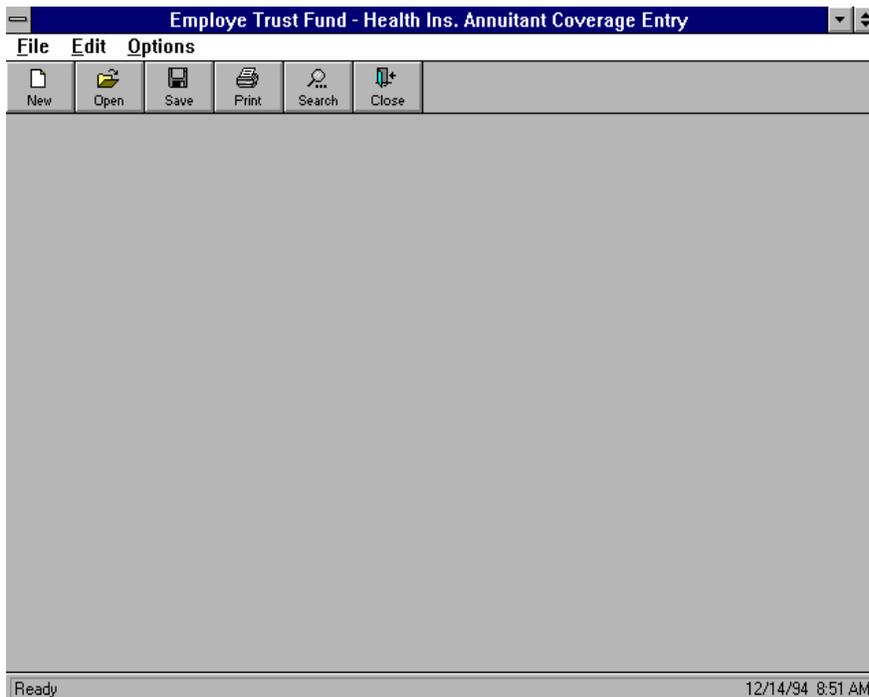
<b>Coverage Month</b>	Required	Insert the Coverage month (01-12), then press <b>ENTER</b> .
<b>Coverage Year</b>	Required	Insert the Coverage year (YYYY), then press <b>ENTER</b> .
<b>EIN</b>	Required	Insert the last seven digits of your Employer Identification Number (EIN). If your EIN is 69-036-1234-000, 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 Screen for Employer-Paid Annuitants

- A. If you report Coverage for your retired employees who are classified as Employer-Paid Annuitants, those Contracts must be entered by accessing the Local Annuitant Coverage Icon. *Double Click* on the Local Annuitant Coverage Icon. The following Main Menu will appear. The menu names on the menu bar are the same as used for active employees in Subchapter 1207.

This 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.



- B. The following Screen allows employers to enter/edit/print Coverage information for retired employees who are classified as Employer Paid Annuitants.  
NOTE: Retired employees health insurance premium rates may be at the Medicare Rate in the event the annuitant is eligible for Medicare. (**See Subchapter 606 entitled Employer Paid Annuitant Medicare Reporting Requirements.**) If a retired employee is not eligible for Medicare, their Contract information should be entered as either **Single Coverage** or **Family Coverage**.
- C. Double clicking on either **New** or **Open** will activate a **Coverage Entry Screen**.

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*This screen allows users to enter/edit/print coverage reports*

The Buttons and Fields in Subchapter 1207 are the same for Annuitants. In addition, the following fields appear:

**Fields:**

- |                                 |           |   |
|---------------------------------|-----------|---|
| <b>Med 1 Sngl<br/>Last MT</b>   | Required  | Total of last month's Med 1 Single Contracts.   |
| <b>Med 1 Sngl<br/>Adds</b>      | Displayed | Total number of Med 1 Single Contracts entered as additions on the Adjustment Entry Screen.             |
| <b>Med 1 Sngl<br/>Dels</b>      | Displayed | Total number of Med 1 Single Contracts entered as deletions on the Adjustment Entry Screen.             |
| <b>Med 1 Sngl<br/>Chgs To</b>   | Displayed | Total number of Med 1 Single Contracts entered as Change To on the Coverage Entry Adjustment Screen.    |
| <b>Med 1 Sngl<br/>Chgs From</b> | Displayed | Total number of Med 1 Single Contracts entered as Changes From on the Coverage Entry Adjustment Screen. |

<b>Med 1 Sngl Total</b>	Displayed	Total number of Med 1 Single Contracts. Once <b>SAVED</b> and the <b>Roll Forward</b> Function activated, this <b>Total</b> will become the next month's beginning Contracts.
<b>Med 1 Sngl Prem Amt</b>	Displayed	Total premiums for Med 1 Single Contracts.
<b>Med 2 Fmly Last MT</b>	Required	Total number of last month's Med 2 Family Contracts.
<b>Med 2 Fmly Adds</b>	Displayed	Total number of Med 2 Family Contracts entered as additions on the Coverage Entry Adjustment Entry Screen.
<b>Med 2 Fmly Dels</b>	Displayed	Total number of Med 2 Family Contracts entered as deletions on the Adjustment Entry Screen.
<b>Med 2 Fmly Chgs To</b>	Displayed	Total number of Med 2 Family Contracts entered as Changes To on the Adjustment Entry Screen.
<b>Med 2 Fmly Chgs From</b>	Displayed	Total number of Med 2 Family Contracts entered as Changes From on the Adjustment Entry Screen.
<b>Med 2 Fmly Total</b>	Displayed	Total number of Med 2 Family Contracts. Once <b>SAVED</b> and the <b>Roll Forward</b> Function activated, this <b>Total</b> will become the next month's beginning Contracts.
<b>Med 2 Fmly Prem Amt</b>	Displayed	Total premiums for Med 2 Family Contracts.
<b>Med 1 Fmly Last MT</b>	Required	Total of last month's Med 1 Family Contracts.
<b>Med 1 Fmly Adds</b>	Displayed	Total number of Me 1 Family Contracts entered as additions on the Adjustment Entry Screen.
<b>Med 1 Fmly Dels</b>	Displayed	Total number of Med 1 Family Contracts entered as deletions on the Adjustment Entry Screen.
<b>Med 1 Fmly Chgs To</b>	Displayed	Total number of Med 1 Family Contracts entered as Changes To on the Adjustment Entry Screen.
<b>Med 1 Fmly Chgs From</b>	Displayed	Total number of Med 1 Family Contracts entered as Changes From on the Adjustment Entry Screen.
<b>Med 1 Fmly Total</b>	Displayed	Total of Med 1 Family Contracts. Once <b>SAVED</b> and the <b>Roll Forward</b> Function activated. This <b>Total</b> will become the next month's beginning Contracts.

**Med 1 Fmly**    Displayed    Total premiums for Med 1 Family Contracts.  
**Prem Amts**

**1209 Coverage Entry Adjustment Screen for Active and Retired Employees**

*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.

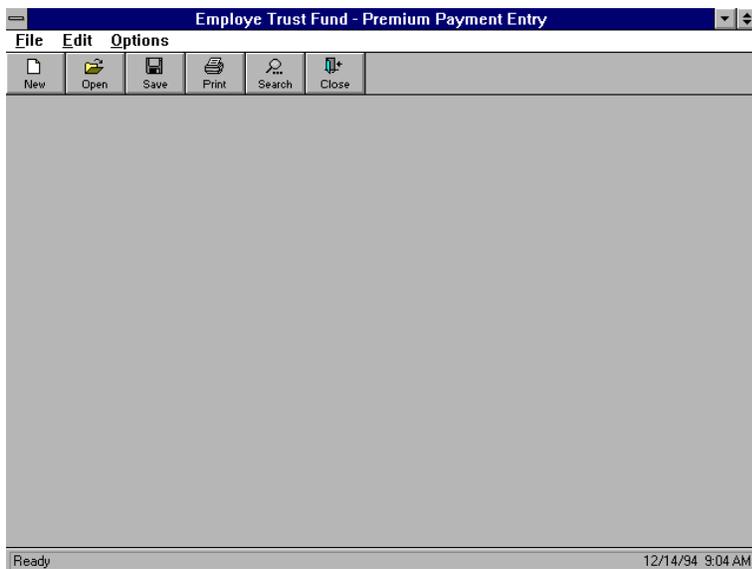
<b>Carrier Name</b>	Displayed	Carrier Name.
<b>Adjustment Type</b>	Required	<p>Type a valid Adjustment Type, or click on the Pull Down Arrow to display applicable Adjustment Types via a Pull Down Window. (Only the codes appear; there was not ample room to include the descriptions.) Once the Adjustment 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.

## 1210 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:

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

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

- |                      |  |
|----------------------|--|
| <b>File, New...</b>  | Also accessed by clicking <b>New</b> 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. |
| <b>File, Open...</b> | Also accessed by clicking <b>Open</b> on the button bar. If <b>Open</b> 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 briefly 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:**

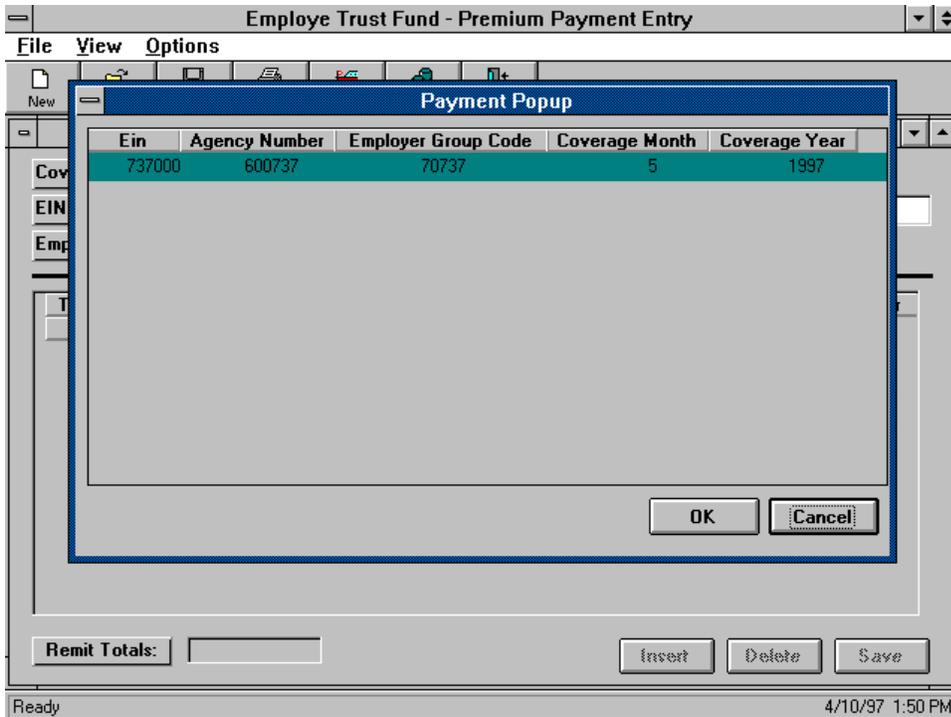
- Insert**      Inserts a blank record and allows users to fill in the empty fields with premium payment information.
- Delete**     Removes the entire record from the database. Click anywhere between the fields of the record to highlight the entire record. Click the **Delete** button to remove the record.
- 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.

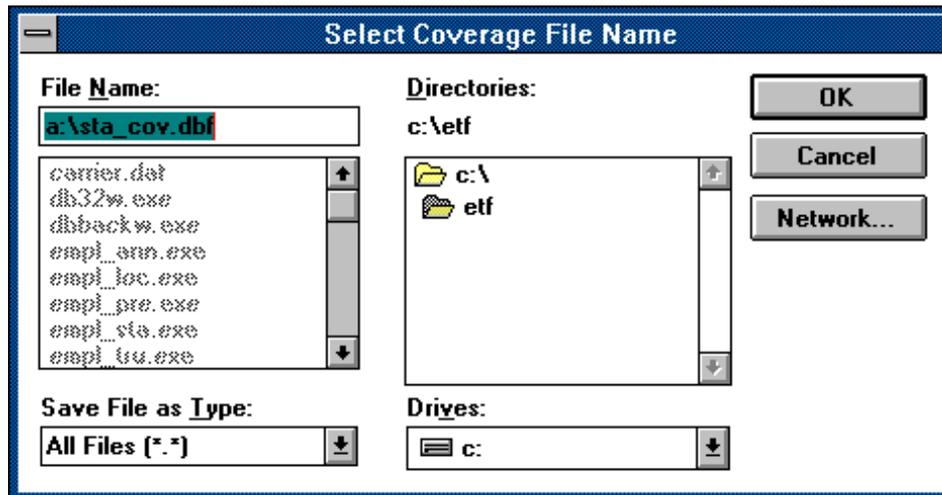
**1211 Export**

- 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. Local employers with annuitants must export files from the local coverage program and the local annuitant coverage program. All four files should be exported to a single floppy disk. 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.



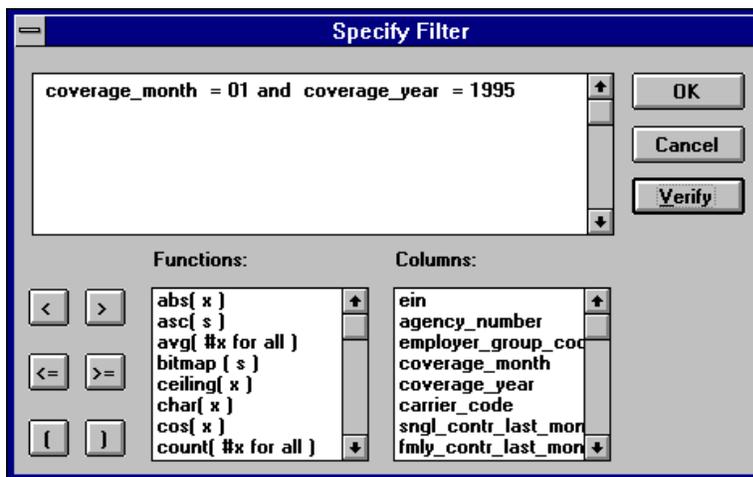
2. Insert the Coverage Month containing the data you have selected to be exported in the Export Month field using the (01-12) format, press **TAB** and insert the Export Year (YYYY), then click on **OK**.



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.

## 1212 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."



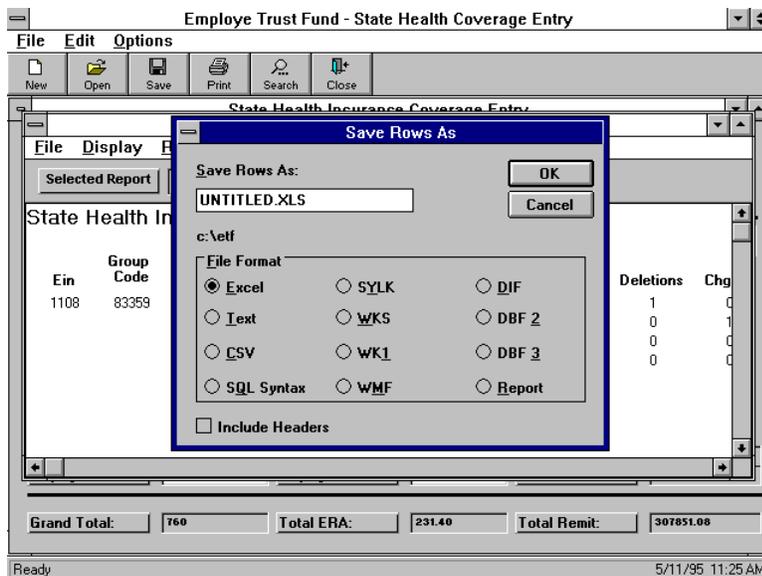
- b. Highlight and single click on the "**coverage\_month**" within the Columns box. This will display within a data-entry window. Type "=" followed by the designated coverage month (**MM**). Type "**and**."
  - c. Highlight and single click on the "**coverage\_year**" within the Columns box. This will 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**.

### 1213 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.).

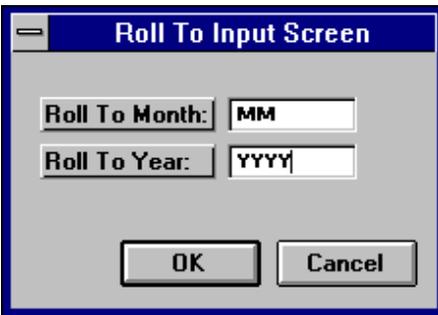


- B. To activate the **Formatting Function**, do the following:
  1. Click on **Print** in the Menu Bar.
  2. Select a **Report** using the Pull Down Arrow.
  3. Click on **Rows**.
  4. Select **Save Rows As**.
  5. Select the file format to be used, and click on **OK**.

### 1214 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.

## 1215 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.

## 1216 Generation of Paper Copies of Reports

- A. Local Health Insurance - Individual Carriers and, if applicable, Local Annuitant 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 Local Health Insurance and Local Annuitant 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.

Local Health Insurance - Individual Carriers Sample

Local Health Insurance - Individual Carriers

Ein	Group Number	Agency Number	Employer Name	Coverage Month/Year	Carrier Code	Carrier Name	Last Month	Additions	Deletions	Chg To	Chg From	Total Contr	Premiums	
991000	70991	600991	MADISON, CITY	10 1996	15	DEANCARE								
				Sngl: 283	6	-2	1	-4	284	46,899.76	1021	Total Contracts		
				Fmly: 730	5	-1	4	-1	737	302,995.44	349,895.20	Total Premiums		
											350,698.13	Employer Share		
											2,152.29	Employer Share		
											352,850.42	Grand Total		
											2,955.22	Total Adj.		
DEANCARE														
				Sngl: 283	6	-2	1	-4	284	46,899.76	1021	Total Contracts		
				Fmly: 730	5	-1	4	-1	737	302,995.44	349,895.20	Total Premiums		
											350,698.13	Employer Share		
											2,152.29	Employer Share		
											352,850.42	Grand Total		
											2,955.22	Total Adj.		
Carrier Totals: 15														

- B. Local Health Insurance - Adjustments and, if applicable, Local Annuitant Health Insurance - Adjustments (i.e., Monthly Additions, Changes and Deletions Reports)
1. If you report any type of Adjustment Contracts for a Carrier, Local Health Insurance and Local Annuitant 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. Local 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.

Local Health Insurance - Adjustments Sample

Local Health Insurance - Adjustments

Ein	Group Number	Agency Number	Employer Name	Adj. Type	Emp. Type	Coverage Month/Year	Carrier Code	Carrier Name	Soc Sec No.	Effic. Dt.	Old Code	New Code	Begin MM/YY	End MM/YY	Adj. Amount	
991000	70991	600991	MADISON, CITY	A	2	6	10	1996	15	DEANCARE	0	2	09/96	09/96	411.12	
991000	70991	600991	MADISON, CITY	A	2	6	10	1996	15	DEANCARE	0	1	00/00	00/00	0.00	
991000	70991	600991	MADISON, CITY	A	2	6	10	1996	15	DEANCARE	0	2	09/96	09/96	411.12	
991000	70991	600991	MADISON, CITY	C	0	0	10	1996	15	DEANCARE	1	2	09/96	09/96	245.98	
991000	70991	600991	MADISON, CITY	D	49	6	10	1996	15	DEANCARE	1	0	08/96	09/96	-330.28	
991000	70991	600991	MADISON, CITY	D	10	6	10	1996	15	DEANCARE	2	0	00/00	00/00	0.00	
991000	70991	600991	MADISON, CITY	D	49	6	10	1996	15	DEANCARE	1	0	08/96	09/96	-330.28	
															Totals:	407.66

- C. Local Health Insurance - Standard Totals and, if applicable, Local Annuitant Health Insurance - 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. Local Health Insurance - Alternate Totals, and if applicable, Local Annuitant 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.

Local Health Insurance - Alternate Totals Sample

Local Health Insurance - Alternate Carrier Totals

Ein	Group Number	Agency Number	Employer Name	Coverage Months/Year	Deletions		Chg From		Total Contr	Premiums
					Additions	Deletions	Chg To	Chg From		
991000	70991	600991	MADISON, CITY	10	1996					
				8	-4	0	-3	696	124,754.96	2107 Total Contracts
				2	-3	3	0	1411	626,280.06	750,035.01 Total Premiums
										713,983.84 Employer Share
										40,474.85 Employee Share
										754,458.69 Grand Total
										4,423.68 Total Adj.

- E. Local Health Insurance - Grand Totals, and if applicable, Local Annuitant 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.



**Department of Employee Trust Funds**  
**LOCAL 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-1318	Resolution to Withdraw from the Wisconsin Public Employers' Group Health Insurance Program	106
ET-1615	Group Health Insurance Transfer Report	503, 602, 603, 607
ET-1630 ET-1643 ET-1645 ET-1647 ET-1648 ET-1657 ET-1658	Monthly Coverage Report	408, 410, 501, 502, 503, 504, 505, 506, 507, 511, 602, 603, 604, 605, 606, 607, 805
ET-1631 ET-1644 ET-1649 ET-1650 ET-1652 ET-1653 ET-1654 ET-1655	Health Insurance Summary	501, 505, 506, 507, 511, 602, 604, 605
ET-1728	Health Plan Contacts	206
ET-2119	Your Benefit Handbook	109
ET-2128	It's Your Choice	102, 103, 109, 203, 206, 207, 302, 303, 306, 308, 401, 803, 806
ET-2131	Wisconsin Public Employers Standard and SMP Plan	109
ET-2301	Group Health Insurance Application	109, 303, 304, 305, 306, 307, 309, 310, 401, 402, 403, 404, 406, 407, 411, 502, 503, 504, 507, 703, 704, 707, 803, 902, 903, 1001
ET-2304	Life Insurance Application/Cancellation/Refusal	903

Form Number	Form Name	Referenced in Subchapter(s)
ET-2307	Income Continuation Insurance Application	903
ET-2311	Continuation – Conversion Notice	109, 311, 401, 503, 504, 703, 704, 707, 708, 801
ET-2319	Rehired Annuitant Election	901, 902
ET-2325	Converting Your Group Life Insurance to Pay Health or Long-Term Care Insurance Premiums	804
ET-2329	Health Insurance Information Change	109, 406, 407, 408, 409, 707
ET-2343	Initial Offering Group Health Insurance Application	306
ET-2405	Insurance Complaint	104, 105, 109
ET-2610	Monthly Additions Report	306, 401, 501, 502, 503, 504, 505, 507, 511, 602, 603, 604
ET-2612	Monthly Deletions Report	401, 410, 411, 501, 502, 503, 504, 505, 507, 511, 602, 603, 604, 607, 805
ET-2614	Monthly Changes Report	501, 504, 505, 507, 511, 602, 604, 606
ET-4112	Group Health Insurance	801
ET-4307	Medicare Eligibility Statement	606, 802
ET-4814	Employer Verification of Health Insurance Coverage	503, 702, 801, 803, 805, 806
ET-6101	Death Benefits	109

## 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
WPE	Wisconsin Public Employers
WRS	Wisconsin Retirement System