UNIVERSITY OF WISCONSIN
ELECTION OF CONTINUED VISION COVERAGE
To be completed by Enrollee

DESCRIPTION OF QUALIFYING EVENT:

☐ Divorce – Effective Date _____	☐ Retiree
☐ Termination of Domestic Partnership – Effective Date _____	☐ Surviving Dependents
☐ Loss of child's dependent status – Effective Date _____	☐ Termination of Employment

COBRA APPLICANT INFORMATION (to be completed by Enrollee): Please type or print

Name of COBRA Applicant (Last, First, Middle Initial)	Daytime Telephone Number	Sex ☐ Male ☐ Female
Mailing Address (Number, Street, City, State, ZIP)		
Social Security Number	Birth Date (mm/dd/yyyy)	Marital Status ☐ Married ☐ Single

CURRENT/FORMER EMPLOYEE INFORMATION (to be completed by Enrollee):

Name of Employee	Social Security Number of Employee	Relationship to Applicant

Choose your VSP coverage (monthly rate):	☐Enrollee Only- $6.54	☐ Enrollee + Spouse/ Domestic Partner- $13.08	☐ Enrollee + Child(ren) - $14.73	☐ Enrollee + Family - $23.54

ELIGIBLE FAMILY MEMBERS (List dependents to be enrolled. Attach separate listing if more dependents exist.):

Name (Last, First, Middle Initial):	Social Security Number:	Birth Date (mm/dd/yy)	Sex	Relationship to Employee
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	
			☐ Male ☐ Female	

ELIGIBILITY PERIODS:

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows an employee whose group insurance terminates due to termination of employment - for reasons other than gross misconduct - to continue their insurance coverage for themselves for up to 18 months. Surviving dependents, divorced or legally separated spouses and dependents, and children who lose coverage due to age or marriage may continue their coverage for up to 36 months. COBRA allows temporary extension of benefits only.

ELECTION CONTINUATION OF VISION CARE COVERAGE AND PAYMENT REQUIREMENTS:

This form must be mailed within 60 days from the date it was received by the COBRA applicant to elect continuation of vision care coverage. After 60 days, the election period ends and eligibility ceases. To continue vision coverage through Vision Service Plan (VSP), monthly premium must be received by the 1st of each month. (i.e., April premium must be received by April 1st). Failure to pay premiums will result in the termination of coverage.

PAYMENT AGREEMENT (to be completed by Enrollee):

☐ I elect to continue vision coverage at a rate of $____.___ per month as shown above for the level of coverage I am electing. Premium may increase with employer's rate. Do not include payment with this form. VSP will direct-bill you. Retirees will be billed in full for the premium due for the remainder of the calendar year.

NOTIFICATION AGREEMENT and SIGNATURES (Parent or Legal Guardian must sign if dependents are minor children):

I certify that I am not covered under any other group vision plan at this time. Should I become eligible under another group plan, I will notify VSP in writing to terminate my vision care coverage within 30 days of the effective date of the other coverage.

Signature of COBRA Applicant:	Date: (mm/dd/yy)

RETURN COMPLETED FORM TO: VISION SERVICE PLAN, PO BOX 997100, SACRAMENTO, CA 95899-7100 QUESTIONS CALL: 800-400-4569

For Office Use Only – Complete prior to providing this form to the member

Person ID:	Campus/Location:	Coverage Term Date:	Date Form was Provided:	Issued By:	Deduction Code:	Group Number: 30015848/5001/5001