EPIC SPECIALTY BENEFITS

EPIC BENEFITS+ CONTINUATION FORM

Please print clearly or type - Submit completed form to EPIC Specialty Benefits

SECTION 1: APPLICANT INFORMATION

Please provide your legal name, your complete address where you want all your mail to be delivered, a daytime telephone number or email address where you can be reached or a message can be left, date of birth, gender, and social security number and your current EPIC Benefits+ customer number. This information insures accurate and timely enrollment and changes to your EPIC account.

Annuitant Name (last, first, middle)		Social Security Number	Email Address	
Street Address		City	State	Zip Code
Daytime Telephone Number	EPIC Benefits+ ID Number	Prior State Employer	Date of Birth (MM/DD/CCYY)	Gender ☐ Male ☐ Female

SECTION 2: REASON CONTINUATION ELECTED (Qualifying Event)

☐ I have less than 20 years of creditable WRS service and am terminating employment end date:__________________

☐ I have applied for a retirement annuity from the Wisconsin Reitrement System (WRS); or I have 20 years of creditable WRS service and I am eligible to apply for an immediate annuity; or I have 20 years of creditable WRS service, am terminating employment and remain a WRS participant - employment end date:______________________

Annuitant appliction must be submitted to EPIC within 60 days of their eligibility date.

☐ Divorce/end of domestic partnership* - event date:____

☐ Dependent no longer eligible* - event date:____

☐ Other* (explain):____

SECTION 3: COVERAGE TO BE CONTINUED (Check one below)

Select which coverage fits your specific needs.

☐ Single Coverage ☐ Former Employee + Spouse/Domestic Partner Coverage

☐ Former Employee + Child(ren) ☐ Family [Former Employee, spouse/domestic partner and child(ren)]

SECTION 4: COMPLETE THE FOLLOWING INFORMATION ONLY FOR INDIVIDUALS COVERED BY THE POLICY (Use additional paper if needed to list all dependents)

Name	Date of Birth (MM/DD/CCYY)	Gender (M/F)	Social Security Number	Relationship to Applicant	Disabled (Y/N)	Tax Dep (Y/N)
		☐M ☐F			☐Y ☐N	☐Y ☐N
		☐M ☐F			☐Y ☐N	☐Y ☐N

SECTION 5: PREMIUM PAYMENT

This application for Benefits+ Coverage Insurance must be submitted to EPIC no later than 60 days of the date shown under "Date of Notice" in the Employer Use Only section below. Premium payments for continuation of coverage will be billed by EPIC and paid to EPIC.

You may elect to receive and pay your premium by mail:

☐ Annually ☐ Semi-Annually ($2.00 fee) ☐ Quarterly ($2.00 fee)

You may elect to have premiums deducted directly from your bank through Electronic Fund Transfer:

☐ Semi-Annually ☐ Quarterly ☐ Monthly

From:

☐ Checking - Include a voided check

☐ Savings - Provide: Account #________________________________ Routing #______________________________

Billing statements are not provided when electronic fund transfer is selected.

This authorization will remain in effect until I notify EPIC Specialty Benefits in writing of the termination. My notification must allow EPIC Specialty Benefits and my financial institution reasonable opportunity to discontinue the premium deduction.

SIGNATURE – (Sign here and return completed application to EPIC)

☐ **I apply for the coverage elected above. I understand that Wis. Stats. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct. I agree to the provisions of the plan. I understand that once enrolled this coverage must remain in force for the full calendar year unless eligibility is lost.**

Applicant Signature	**Date** (MM/DD/CCYY)

FOR EMPLOYER USE ONLY - COMPLETE BEFORE ISSUING FORM

Extension of group coverage is in compliance with ☐ Retiree Continuation ☐ COBRA ☐ COBRA/Continuation			Applicant is Eligible to Continue: ☐ Yes ☐ No	Paid Through Date:
Completed By:	Telephone #:	Date Notified of Term:	Date of Notice:	Name of Employer:

PLEASE RETURN THIS FORM TO:

EPIC Specialty Benefits, P.O. Box 8430, Madison, WI 53708-8430