Date\_\_\_\_\_\_\_\_\_\_\_\_

Dear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

According to Wisconsin state law, continuation of your health insurance coverage is being offered under the following stipulations.

1. You are responsible to pay the full premium of $\_\_\_\_\_\_ per month. Should you fail to pay the premium by the date specified below, your insurance will be terminated.
2. Premium MUST be received by the employer by the 20th of every month. This payment will be applied to the following month’s coverage. Failure to pay this premium by the date listed will cause a termination in coverage. Check or money order should be addressed to your ex-employer. (Example: If listed as the 20th, the premium for February must be received by the employer by January 20th.)
3. This option is available for 18 months beginning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and ending \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, but can be terminated by you at any time. For you to terminate your coverage it is suggested that you notify the ex-employer in writing.
4. If you choose to continue your coverage, you have 30 days to return the letter with the appropriate premium to your ex-employer. Failure to return both the signed letter and check will be considered a waiver of continuation rights.

Please indicate your decision below and mail back to this office.

(Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Yes.**  I have decided to take the continuation of coverage option. And I agree to comply with all of the rules and regulations regarding state continuation. A payment is also enclosed.

(Signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **No.** I have decided **not** to take the state continuation coverage option.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_