EPIC LIFE INSURANCE

DENTAL WISCONSIN CONTINUATION FORM

Underwritten by The EPIC Life Insurance Company
Please print clearly or type - Submit form to EPIC

Employee Name (Last, First, Middle)		Applicant Name (if different from employee name)	
Applicant Address (Street, City, State, Zip)		Applicant Phone Number ( )	Employee/Applicant D.O.B.
Applicant Social Security Number	Dental WI Member ID Number	Current Plan ❑ PPO ❑ Select	Group Number

Section 1: Reason Continuation Elected (qualifying event)

❑ End of employment - enter employment end date: _____ (mm/dd/yyyy)

❑ Retirement (indefinite continuation) - enter retirement date: _____ (mm/dd/yyyy)

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

❑ Divorce/end of domestic partnership* - enter event date: _____ (mm/dd/yyyy)

❑ Dependent no longer eligible* - enter event date: _____ (mm/dd/yyyy)

❑ Other* (explain): _____

Section 2: Coverage to Be Continued (check one below)

❑ Single coverage ❑ Employee + Spouse/Domestic Partner coverage
❑ Applicant + Child(ren) ❑ Family [former employee, spouse/domestic partner and child(ren)]

Section 3: Complete the following information ONLY for individuals covered by the policy

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

Section 4: Premium Payment

For non-annuitants, this application for Continuation of Insurance must be submitted to EPIC within 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 account 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 transfer is selected.

This authorization will remain in effect until I notify The EPIC Life Insurance Company in writing of the termination or until the continuation period expires. My notification must allow The EPIC Life Insurance Company and my financial institution reasonable opportunity to discontinue the premium deduction.

Section 5: Signature of Applicant - date and sign continuation form below:

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

PLEASE RETURN THIS FORM TO:
The EPIC Life Insurance Company - P.O. Box 8430 - Madison, WI 53708-8430

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: