



# EPIC BENEFITS+ 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 Date of Birth (mm/dd/yy)
Applicant Social Security Number	EPIC Benefits+ Member ID Number	Current Plan <input type="checkbox"/> With Vision Discount Only <input type="checkbox"/> With Vision Insurance	

### Section 1: Reason Continuation Elected (qualifying event)

- I have less than 20 years of creditable WRS service and am terminating employment – employment end date: \_\_\_\_\_
- I have applied for a retirement annuity from the Wisconsin Retirement 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 application must be submitted to EPIC within 30 days of their eligibility date.*
- Divorce/end of domestic partnership\* – event date: \_\_\_\_\_
- Dependent no longer eligible\* - event date: \_\_\_\_\_
- Other\* (explain): \_\_\_\_\_

\*If the person selecting continuation coverage is not the former employee, include a completed EPIC Benefits+ application with this form.

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

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

### Section 3: Premium Payment

For non-annuitants, this application for Continuation of Insurance must be submitted to EPIC in a timely manner as outlined in your Certificate of Insurance under the Group Continuation Section. 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 EPIC Life Insurance Company in writing of the termination or until the continuation period expires. My notification must allow EPIC Life Insurance Company and my financial institution reasonable opportunity to discontinue the premium deduction.

### Section 4: Signature of Applicant – date and sign continuation form below:

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

Please return this form to:

**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: <input type="checkbox"/> Retiree Continuation <input type="checkbox"/> COBRA <input type="checkbox"/> Domestic Partner Continuation		Applicant is Eligible to Continue: <input type="checkbox"/> Yes <input type="checkbox"/> No		Paid Through Date:
Completed By:	Telephone #:	Date Notified of Term:	Date of Notice:	Name of Employer: