WISCONSIN
NOTICE OF CONTINUATION RIGHT

GROUP: _____ DATE: _____

EMPLOYEE OR DEPENDENT: _____

DATE OF TERMINATION: _____

MONTHLY HEALTH PREMIUM: _____

PREMIUM DUE DATE: _____

You may continue under this Group health policy if you have been insured continuously under this Group for 3 months and:

1. you have not converted to an individual health policy; and
2. your insurance terminated because:
   a. you are no longer the spouse of an insured employee because of divorce or annulment; or
   b. you are no longer an eligible employee under the Group. However, if you were discharged for misconduct in connection with your job, you cannot continue your or your dependents insurance; or
   c. you are no longer an eligible dependent because the insured employee died.

If you meet the above conditions and desire to continue under the Group health policy, you must send the first month's premium and this signed form to the Group within 30 days from the date of this notice. Subsequent premiums must be received by the Group on or before the premium due date each month. You will not receive any reminder to pay the premium.

See the "Continuation of Health Coverage" page in your certificate booklet for a more detailed explanation.

_____ _____

Date Signature