45 Nob Hill Road | Madison, Wisconsin 53713
800.279.4000 WEAtrust.com

Loss of Health Coverage

If you lose health insurance, you have **30 days** to apply for health insurance through WEA Trust.

1. **You** complete the **Employee Information.**
2. **Other health insurance company** completes the **Health Insurance Information.**
3. Submit this form and your health insurance enrollment form (**within 30 days** after you lost insurance).

EMPLOYEE INFORMATION

You complete this section.

Your Name:____________________ Telephone No: (______)__________

Subscriber Number:____________________

Group Name:____________________ Group No.:________________

Your Employment Start Date:______/____/____ Telephone No.: (______)__________

HEALTH INSURANCE INFORMATION

Former employer or health insurance company completes this section.

Name of Employer:____________________

Name of Health Insurer:____________________ Telephone No.: (______)__________

Insured's Name:____________________ Policy No.________________

Coverage Termination Date:______/____/____

Reason for Termination:____________________________________

List all family members who were covered by the plan:

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

____________________ ____________________

Signature of Individual Completing "Health Insurance Information" Section — Date

____

Print Name and Title