



# Benefit Plans Office

Date:

Member Name:

Dependent:

Member ID:

Dependent Date of Birth:

Dear Member:

Please complete and return this form to the WELS Benefit Plans Office or FAX the completed form to (414) 256-3879.

- A. **General Information.** Based upon our records, your above-named unmarried, dependent child has qualified for dependent coverage under the WELS VEBA Group Health Care Plan (“Plan”) based upon his/her status as a full-time student at an educational institution. If he/she ceases to be a full-time student, then, in general, his/her status as your dependent under the Plan will terminate and his/her coverage under the Plan will terminate at the end of the calendar quarter in which he/she is no longer a full-time student. *Michelle’s Law*, however, provides an exception to this general rule.

**Michelle’s Law**—If an unmarried dependent child ceases to qualify as a full-time student because he/she was on a medically necessary leave of absence from a post-secondary educational institution as a result of a serious injury or illness that he/she suffered, then he/she can continue to be covered as a dependent until the earlier of (a) the date that is one-year after the date such medical leave of absence began, or (b) the date Plan coverage would otherwise terminate (for example, due to the child otherwise ceasing to qualify as a dependent under the Plan’s terms). A dependent child will not qualify for this continued coverage, however, unless the treating physician certifies in writing that the child is suffering from a serious illness or injury and that the leave of absence from the post-secondary educational institution is medically necessary. *Michelle’s Law* applies to the Plan beginning January 1, 2010, with respect to medically necessary leaves of absence that begin on or after that date. If a dependent child continues coverage under *Michelle’s Law*, he/she will be entitled to the same coverage during the medically necessary leave of absence as if he/she had continued as a covered student at the post-secondary educational institution and was not on a medically necessary leave of absence.

*(Note: If your child will lose coverage because he/she no longer qualifies as a dependent, he/she may elect to continue Plan coverage under the Plan’s COBRA coverage continuation rules. Please see the summary plan description for the Plan for a more detailed explanation of the COBRA coverage continuation rules.)*

- B. **Review of Student Status.** Is the above-named, unmarried dependent child a full-time student at an educational institution? (Check one and complete as necessary)

**YES** Please provide the following information and sign and date the form on page 2:

School’s name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Semester Start Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Anticipated Graduation Date (Month/Year): \_\_\_\_\_/\_\_\_\_\_  
(If applicable, must be completed.)

**NO** If you answered "no," did the above-named dependent cease to be a full-time student at an educational institution as a result of a medically necessary leave of absence resulting from a serious injury or illness that he/she suffered? (Check one box and complete as necessary)

**YES** Please have the attending physician complete the certification below and provide the following information:

School's name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Semester Start Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Anticipated Graduation Date (Month/Year): \_\_\_\_\_/\_\_\_\_\_  
(If applicable, must be completed.)

Date dependent's medical leave began: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**NO** If you answered "no," when did the last semester attended end?  
(Month/Year): \_\_\_\_\_/\_\_\_\_\_

I certify that the above information is true and complete.

**Member Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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### PHYSICIAN'S CERTIFICATION

*(To be completed by the attending physician only if the above-named dependent's absence from school is due to a medically necessary leave of absence)*

The undersigned physician certifies that the above-named dependent student is suffering from a serious illness or injury and that the dependent's leave of absence (or other change in enrollment of the dependent at the above-named school) is medically necessary.

Describe dependent's medical condition:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of dependent's medical leave:

Beginning Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ End Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I hereby certify that the above information is true and complete.

\_\_\_\_\_  
**Signature of Attending Physician**

**Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_