Layoff Extension Application for COVID-19 Assistance

This extension of health benefits coverage is available for use April 1, 2020 through September 1, 2020. In order to receive your four (4) week layoff extension, this form must be completed in its entirety. Your coverage must have been active at the time of layoff, and layoff must be due solely to COVID-19.

PART A: To be completed by the covered Member claiming benefit

Name of Member (Please Print): _____

Member's ID Number: _____

Address: _____

Name of Employer: _____

I understand that for the above requested layoff extension, I will only have those health benefits to which I was entitled as of April 1, 2020, and that the extension does not include loss of time (short term disability), life insurance, or accidental death and dismemberment benefits.

Member's Signature: _____ Date: _____

PART B: To be completed by the Employer

When you, the Employer, are no longer submitting Health & Welfare contributions for an employee, Wisconsin Health Fund asks you to complete this form. To qualify for this extension, your layoff of the above employee must be due solely to the effects of COVID-19.

Above Employee's Date of Layoff: _____

Name of Employer: _____

Authorized Printed Name: _____ Phone Number: _____

Authorized Signature and Title: _____

This form needs to be received by Wisconsin Health Fund in a timely manner. All parts of this form must be completed to assure validity and to provide benefits.

Please send completed form to: **Attention Kathy Nelson Wisconsin Health Fund** By either:

Mail: 6200 W. Bluemound Rd., Milwaukee, WI 53213; or
Fax: 414-257-9705; or
Email: knelson@whfund.org