State of Wisconsin
Dept of Workforce Development
Equal Rights Division

Cessation of Health Care Benefits Complaint

Office Use Only

Personal information you provide may be used for secondary purposes. [Privacy Law, Section 15.04(1)(m) Wisconsin Statutes].
This law applies to businesses with 50 or more employees in the State of Wisconsin. Businesses that employ fewer than 50 employees do not have to give notice when deciding to cease providing health care benefits to their employees.
If the law applies, employers must give 60-day's advance notice to employees, retirees, and their dependents before terminating a health care benefit plan.

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The law does not require that employers notify employees who are terminated or who quit that their health care benefits will cease. Notice is only required when a health care benefit plan is being terminated for an entire class of employees.

The law does not require that employers give notice before making changes to an existing plan.

For more detailed information, please refer to publication ERD-11054-P, "Notification Required for Cessation of Health Care Benefits".

Please Type or Print in Black Ink All Applicable Information

Complainant Information		**Employer Information**
☐ Mr. ☐ Ms. ☐ Mrs. Print your name		Business Name
Your Street Address		Owner/Corporation Name
City, State, Zip Code		Business Street Address
Home Telephone Number ( ) Work Telephone Number ( )		City, State, Zip Code
Your Social Security Number	Date of Birth	Business Telephone Number ( )
Your E-mail Address		Type of Business

Filing Information

Are you

☐ currently employed by the business
☐ a former employee of the business
☐ a dependent of an employee or retiree
☐ retired from the business
☐ a Union Representative

Company official to contact for further information		Telephone Number ( )		Date health care benefits ceased
Name of Health Insurance carrier				
Street Address	City	State	Zip Code	Telephone Number ( )
Estimated number of employees this business employs in the State of Wisconsin				

You must also complete page 2

Estimated number of employees who lost their health care benefits
Did the business cease providing health care benefits to all employees, retirees and their dependents ☐ Yes ☐ No If not, what specific groups were affected?
Did the business give written notice of its intent to cease providing health care benefits ☐ Yes ☐ No **If yes, include a copy with this complaint and provide date notice was given**
Is the company self-insured ☐ Yes ☐ No If yes, provide date:
Has the employer filed for bankruptcy protection ☐ Yes ☐ No ☐ Don't Know Date Filed Where Filed Bankruptcy Case number
Is the employer in Receivership under Chapter 128, Wisconsin Statutes ☐ Yes ☐ No ☐ Don't Know Date Filed Where Filed Receivership Case number
Is there a Union representing employees ☐ Yes ☐ No Name and address of Local:

Please provide the name, address and telephone number of someone who does not reside with the complainant but who will know where to reach the complainant

Name of contact person				Relationship to Complainant
Street Address	City	State	Zip Code	Telephone Number ( )

Explanation Of The Complaint(Use extra sheets if necessary)

Please enclose copies of any other information relevant to this complaint.
By my signature below, I certify that I have read the above complaint, and, under penalties of law, I declare that this complaint is true and correct to the best of my knowledge and belief. I understand that this complaint is an open record and may be provided to the employer or others under the provisions of Wisconsin's Open Records Law.

Your Signature	Date Signed

Please return completed form to

Department of Workforce Development
Equal Rights Division
PO Box 8928
Madison WI 53708
Telephone Number: (608) 266-6860