

Company official to contact for further information	Telephone Number ()	Date health care benefits ceased
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Name of Health Insurance carrier

Street Address

City, State and Zip Code

Telephone Number
()

Estimated number of employees this business employs in the State of Wisconsin:	Estimated number of employees who lost their health care benefits:
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, include a copy with this complaint and provide date notice was given:	Is the company self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide date:
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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 Section 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:

Name, street address, and telephone number of someone who does not live with you who will always know how to contact you:

Explanation Of The Complaint(Use extra sheets if necessary):

Please enclose copies of any other information relevant to this complaint.
The statements made above are true to the best of my knowledge. I understand if the employer wants to review this complaint, it is an open record.

Your Signature _____ Date Signed _____

Please return completed form to: **Equal Rights Division, Labor Standards Bureau,
P O Box 8928 Madison WI 53708**