

**EXISTING EMPLOYER  
OPTION SELECTION RESOLUTION  
WISCONSIN PUBLIC EMPLOYERS' GROUP HEALTH INSURANCE PROGRAM**

RESOLVED, by the \_\_\_\_\_ of the \_\_\_\_\_  
(Governing Body) (Employer Legal Name)

that pursuant to the provisions of Wis. Stat. § 40.51 (7) hereby determines to offer the Group Health Insurance program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance program will need to be enrolled in one of the four options listed below. An employer may not split its group between the options.

We choose to participate in the: (check only one box)

- Traditional HMO Option paired with the Classic Standard Plan
- Traditional HMO Option paired with the Standard PPP
- Deductible HMO Option paired with the Deductible Standard Plan
- Deductible HMO Option paired with the Deductible Standard PPP

The resolution must be received by the Department of Employee Trust Funds no later than October 1 for coverage to be effective the following January 1.

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

**CERTIFICATION**

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the \_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this \_\_\_\_ day of \_\_\_\_\_, year \_\_\_\_.

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent statements, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

\_\_\_\_\_  
Employer Representative Title

\_\_\_\_\_  
Employer County

\_\_\_\_\_  
Mailing Address

Number of eligible employees \_\_\_\_\_

**69-036-**  
\_\_\_\_\_  
ETF Employer Identification Number