



STATE OF WISCONSIN
Department of Employee Trust Funds

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SECRETARY

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Name:	Social Security Number:
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INCOME CONTINUATION INSURANCE (ICI) AND/OR LONG-TERM DISABILITY INSURANCE (LTDI) REPAYMENT AGREEMENT

In exchange for the payment of benefits under the State of Wisconsin Group Insurance Board's ICI and/or LTDI plan(s) through the Department of Employee Trust Funds (ETF) or its third party administrator (TPA):

1. I understand that ICI and/or LTDI disability benefits will be reduced or offset by certain payments made to me. For ICI, this falls under section 2.15 of the State or Local ICI plan. For LTDI, this comes under section ETF 50.52, Wis. Admin. Code.
2. I further understand that ETF or the TPA may begin paying ICI or LTDI benefits to me prior to the final determination of whether I am entitled to payments from the sources enumerated in the applicable plan language, administrative code or statutes. For example, but not limited to, benefits paid from the Social Security Administration (SSA), Workers Compensation, Wisconsin Retirement System (WRS) and any earnings for services rendered.
3. If I receive income from any or all sources enumerated in the applicable plan language, administrative code or statutes, I agree to repay ETF the lessor of that amount or the gross ICI benefit, plus any applicable interest.
4. I understand that ETF or the TPA may intercept benefit payments from any or all sources enumerated in the applicable plan language, administrative code or statutes.
5. I agree that, if I fail to provide ETF or the TPA with the information necessary to make the appropriate adjustments to the amounts payable to me, there will be an estimated amount deducted from my benefit and I shall repay ETF the amount of the gross benefits received from the sources enumerated in the applicable plan language, administrative code or statutes.
6. I understand that other benefits paid to me may be recovered several years after I received them. Whenever the overpayment is discovered, the amount must be repaid.
7. I agree to pay interest as determined by ETF on the repayment amount calculated (i) from the date the repayment amount becomes paid or payable and (ii) at the annual rate provided in section 40.02, Wis. Stat.

(over)

8. I agree that any repayment obligations under this agreement shall survive my incapacity or my death, and shall become obligations of my guardian or my estate, as the case may be, in the event of my incapacity or death.
9. I understand that the amount offset will be the gross benefit amount prior to any tax deductions, etc. Any difference will be the employee's responsibility to obtain a refund from the IRS or my state's revenue agency.
10. If there is a conflict between this agreement and the plan and/or administrative code, the plan or administrative code will prevail.

If you have any questions or need assistance in understanding or completing this form, please call Aetna at 1-800-960-0052 between 7:45 AM and 4:30 PM (Central Standard Time), Monday through Friday, except holidays.

I've read this document and agree to the provisions. (Failure to sign this form does not relieve you from these obligations.)

Date (MM/DD/CCYY)	Employee's Signature	Telephone Number
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Return completed form to the address indicated on the front page.