

**Wisconsin Public Employers
Income Continuation Insurance Administration Manual**

CHAPTER 3—Enrollment and Application

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300 Enrollment Opportunities

ICI is available to all eligible employees. (Refer to subchapter 200 for further information on eligible employees.) There are two opportunities for an eligible employee to enroll in the ICI Program:

- 1. Initial Enrollment Period** - This enrollment period generally applies to newly hired or rehired employees.
 - The employer must provide an *Income Continuation Insurance (ET-2106)* brochure and *ICI Application - Local Government Employee (ET-2366)* to the employee on his first day of WRS covered employment.
 - An eligible employee may enroll by submitting a completed ICI application to the employer no later than 30 days following the employee's initial ICI eligibility date. (Refer to subchapters 201 and 202.) Employees are required to submit a completed application whether they are enrolling in coverage or declining coverage.
 - The employer must complete the employer information section on all applications and submit them to ETF within 30 days.

Note for Local Elected Officials: The ICI Program provides for immediate enrollment eligibility for local elected officials. Local elected officials are not required to have 6 months of WRS service prior to becoming eligible for ICI coverage. If coverage is desired, they must enroll within 30 days of taking office or being appointed.

- 2. Evidence of Insurability (EOI)** - The *Evidence of Insurability Application (ET-2308)* is required for employees who have missed their initial enrollment period or who are applying for a shorter elimination period (refer to subchapter 400 for further information on elimination periods).
 - Eligible employees may apply at any time prior to age 70 by completing an *Evidence of Insurability Application* and forwarding it directly to ETF. (Refer to subchapter 304 for instructions on completing the *Evidence of Insurability Application*.)

- An application received by ETF more than 30 days after its completion date, i.e., the date the application is signed, will be rejected. The employee will be required to complete a new *Evidence of Insurability Application*.

Enrollment for Supplemental ICI Coverage

Supplemental ICI coverage is available to employees whose gross annual earnings exceed \$64,000. The entire premium for supplemental ICI coverage is paid by the employee. Refer to subchapter 101, Program Features, for more information on Supplemental ICI Coverage.

- The employee may enroll for supplemental ICI coverage along with standard coverage during the initial enrollment period.
- Employees may also enroll for supplemental coverage during the annual open enrollment period from January 1 through March 1. Refer to subchapter 402 for additional information.
- The employee may also apply for supplemental ICI coverage when enrolling for standard ICI coverage through evidence of insurability. (EOI may *not* be used by employees with standard ICI coverage who wish to add supplemental ICI coverage outside of the annual supplemental coverage open enrollment period.)

301 Completion of ICI Application

The following are requirements for filing an ICI application:

- The employee **must** complete the *Income Continuation Insurance Application (ET-2366)* and return the application to the employer no later than 30 days following their initial ICI eligibility date. *A completed application from the employee is required whether enrolling in coverage or declining coverage.*
- An employee who is employed with more than one WRS employer must file a separate ICI application with each employer.
- Employees will be required to complete and file a new application if coverage was denied due to employer error. (Refer to subchapters 1000 and 1001 for information on employer error).
- Employers must complete Part II of the ICI application and forward it to ETF.

The employer must complete the following items on the ICI Application and forward the application to ETF. (Refer to the sample form at the end of this subchapter.)

- A. Previous Service.** Complete this section and indicate the date employee became eligible for WRS coverage at this employer.
- B. Reason to Submit Application and Occurrence Date** (based on information obtained from a WRS previous service check. Refer to subchapter 206 for more information about previous service checks). Check only **one** box in this section.

- **Immediately Eligible On.** Check this box for employees who previously completed six months of service under the WRS, or for local elected officials in the WRS. Indicate the employee's date.
- **New Employee Will have Participated in WRS for Six Calendar Months On.** Check this box for new employees and rehired employees who have not previously completed six calendar months of service under the WRS (State and/or Local service) and indicate the employee's ICI eligibility date. (Refer to subchapters 201 and 202 for information on determining eligibility dates.)
- **Reinstating Coverage Upon Return From Temporary Layoff or Leave of Absence.** Check this box if an employee who previously had ICI coverage takes a leave of absence, allows coverage to lapse and then returns to eligible employment. Insert the date the leave began and the date the employee returned from leave. Indicate the date the employee returned to work. (Exception: If the leave of absence occurred during the employee's first 6 months of WRS service, the "occurrence date" would be the ICI Eligibility date as determined under subchapter 204.)
- **Changed to a Longer Elimination Period Effective On.** Check this box if the employee wants to elect a longer elimination period. An employee may change to a longer elimination period at any time. However, if an employee wants to change to a shorter elimination period, the employee must apply through evidence of insurability. The "effective date" will be the first of the month after the application is received by the employer.
- **Other** - Check this box for a situation that does not fit one of the other categories listed above. For example, if an employee is reinstated through a grievance/settlement, indicate the date the employee returns to work. Refer to subchapter 205 for more information about settlement agreements and reinstatements.

C. Earnings. Use the employee's WRS earnings as reported in the preceding calendar year or, if applicable, the employee's projected calendar year earnings (refer to "Note" below) then:

- Round the calendar year WRS earnings figure to the next higher thousand;
- Divide by 12 to determine the average monthly earnings;
- Enter the average monthly earnings in the earnings box; and
- Check the "Monthly" box.

Note: To determine the equivalent average monthly earnings for a newly hired employee or a current employee with a permanent change in their percentage of appointment, project the annual base salary, round to the next higher thousand and divide by 12.

D. Basis of Employment. Check whether the employee's basis of employment is full-time, part-time, seasonal, etc. If part-time, indicate the percentage of full-time employment.

- E. ICI Monthly Premium.** Premiums are based on earnings entered in the Earnings box and the elimination period selected by the employee. Refer to the Employee Monthly Premium Rates table in subchapters 401 and 402 for information on calculating employer and employee premium rates.
- F. Employer Name.** Use the same name used for Social Security reporting.
- G. Employer Identification Number 69-036.** The Employer Identification Number (EIN) is a 12-digit number beginning with 69-036. Indicate the last seven digits of this number (XXXX-XXX).
- H. Date Application Provided to Employee.**
- I. Date Received by Employer.** The date the employer received the employee's completed application.
- J. Employer Agent Signature.** The WRS agent or designated representative must certify that the information on the application is true and correct.
- K. Telephone Number.** The telephone number of the employer contact person.
- L. Effective Date.** Coverage becomes effective on the first of the month that first occurs during the employee's 30-day enrollment period. For employees applying during the supplemental coverage open enrollment period, coverage is effective April 1st. (Refer to subchapters 201 and 202 for information on ICI eligibility dates, application due dates and coverage effective dates.)

Department of Employee Trust Funds
P.O. Box 7831
Madison, WI 53707-7831

Local Government Employee
Wis. Stat. § 40.61

INCOME CONTINUATION INSURANCE APPLICATION

I. EMPLOYEE: COMPLETE PART I TYPE OR PRINT IN INK, SIGN, AND RETURN TO EMPLOYER					Member ID
Name Address	Last	First	Middle I.	Maiden/Fomer	Social Security Number
	Street No.		Street Name		Birthdate (mm/dd/yyyy)
	City	State	Zip	Country and Mail Code (if not USA)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
<p>Complete sections 1–3 (2 and 3 if applicable) and sign at section 4.</p> <p>1. ICI COVERAGE</p> <p>Check One</p> <p><input type="checkbox"/> I elect ICI coverage and authorize payroll deductions for premiums. If your annual earnings exceed \$84,000.00, go to #2. If not, proceed to #3.</p> <p><input type="checkbox"/> I do not elect ICI coverage. Sign below at #4.</p> <p><input type="checkbox"/> I wish to cancel my ICI coverage. (Checking this box also cancels Supplemental ICI coverage, if in effect.) Sign below at #4.</p>					<p>2. SUPPLEMENTAL ICI COVERAGE: Only available to employees whose annual earnings exceed \$84,000.00 and who are currently enrolled in, or are applying for, ICI coverage.</p> <p>Check One:</p> <p><input type="checkbox"/> I elect Supplemental ICI coverage. I understand that Supplemental ICI premiums are paid by the employee with no employer contribution. I authorize payroll deductions for Supplemental ICI premiums. If already enrolled in ICI coverage, I understand that the elimination period previously selected will be applied to Supplemental ICI coverage. If you elected ICI coverage in #1, go to #3. If you already have ICI coverage, sign below at #4.</p> <p><input type="checkbox"/> I do not elect Supplemental ICI coverage. If you elected ICI coverage in #1, go to #3. If not, sign below at #4.</p> <p><input type="checkbox"/> I wish to cancel my Supplemental ICI coverage. Sign below at #4.</p>
<p>3. I elect the following calendar day elimination period for ICI coverage and Supplemental ICI coverage (if applicable):</p> <p><input type="checkbox"/> 30-day <input type="checkbox"/> 60-day <input type="checkbox"/> 90-day <input type="checkbox"/> 120-day <input type="checkbox"/> 180-day</p>					

4. I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I authorize the monthly employee share premium deduction (indicated below) from my earnings to provide ICI and Supplemental ICI coverage (if selected). I understand that if premiums are not deducted, I do not have ICI coverage.

	Signature of Employee	Telephone Number ()	Date (mm/dd/yyyy)
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Return to employer

II. EMPLOYER: COMPLETE PART II

Reason to submit application (Check appropriate box and indicate occurrence date)	Previous Service - Complete Information
<input type="checkbox"/> Immediately eligible on: <input type="checkbox"/> New employee will have participated in WRS for six calendar months on: <input type="checkbox"/> Retesting coverage upon return from temporary layoff or leave of absence. Date temporary layoff/LOA began: _____ Date employee returned: _____	1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Previous service check, completed <input type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service: <input type="checkbox"/> ONE Sale <input type="checkbox"/> ETF 3. Date WRS participation began with the current employer (mm/dd/yyyy)
<input type="checkbox"/> Changed to a longer elimination period effective on: (Evidence of insurability is required to change to a shorter elimination period.) <input type="checkbox"/> Other (specify): _____	

Earnings	Rate of Employment	ICI Monthly Premiums		Supplemental ICI Monthly Premiums
\$ <input type="checkbox"/> Monthly	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time _____ %	Employee Share	Employer Share	Employee Share
		\$	\$	\$
Employer Name	Employer Agent Signature	Date Application Provided to Employee	Date Received by Employer (mm/dd/yyyy)	
Employer Identification Number (EIN) 69-036		Telephone Number ()	Effective Date (mm/dd/yyyy)	

Copy and Distribute: ETF Employee Employer

ET-2386 (REV 12/2013)



eff.wi.gov

302 Distribution of Copies

The following requirements pertain to the distribution of ICI application copies:

- Once the ‘Employer Section’ is completed, make two photocopies of the application. Employers must retain one copy for verification purposes.
- Forward the original application to ETF, regardless of whether the employee declines, cancels or elects coverage.
- Provide the employee with the second copy for their records.

303 Application Due Date, Premiums and Effective Date of Coverage

Application Type	Premiums/Monthly Earnings	Application Due Date	Coverage Effective Date
Initial enrollment – new employee ICI Application (ET-2366)	For new employees, the projected annual base salary, as of the coverage effective date, is rounded to the next higher thousand and divided by 12 to determine estimated average monthly earnings.	No later than 30 days after initial ICI eligibility date.	First of month that first occurs during the employee’s 30-day enrollment period.
Evidence of Insurability (ET-2308)	For new employees, the projected annual base salary, as of the coverage effective date, is rounded to the next higher thousand and divided by 12 to determine estimated average monthly earnings. For employees who had a full year of earnings reported to WRS in the previous calendar year, the WRS earnings are rounded to the next higher thousand and divided by 12 to determine average monthly earnings.	Must be submitted to ETF no later than 30 days after the date the employee signs the Evidence of Insurability application.	First day of month on or after the EOI application approval date. ETF will notify employer and employee of approval or denial and effective date of coverage, if applicable.
During Leave of Absence	Prepaid premiums continue in the same amount, even if there is an annual premium adjustment period during the leave of absence.	To continue coverage, employee must pay premium prior to end of coverage so there is no lapse in coverage.	May continue coverage up to 36 months.
Union or Military Leave of Absence	Prepaid premiums continue at the same amount, even if there is an annual premium adjustment period during the leave of absence.	To continue coverage, employee must pay premium prior to end of coverage so there is no lapse in coverage.	May continue coverage for duration of the leave.

Application Type	Premiums/Monthly Earnings	Application Due Date	Coverage Effective Date
Return to work after receiving ICI benefits, or after leave of absence and no lapse in premiums.	Average monthly earnings used to determine premiums will remain the same as prior to the leave until employee has worked one full calendar year, after which the earnings amount will be reviewed during the next annual review period. However, premium rates should be adjusted if there has been an annual premium adjustment in the interim.	Not Applicable.	Not applicable – coverage is continuous.
Return to work after leave of absence and lapse in premiums occurred.	Premium resumes at the same amount as before unless there has been an annual premium or salary adjustment in the interim. Average monthly earnings used to determine premiums will remain the same as prior to the leave until employee has worked one full calendar year, after which the earnings amount will be adjusted during the next annual adjustment.	Within 30 days after return to work.	First of month that first occurs during the employee's 30-day enrollment period.
Permanent change in percentage of appointment (i.e., full-time to part-time and vice versa).	Based on projected earnings for the next 12 months, rounded to next higher \$1,000 and divided by 12.	Not Applicable. Employer will be contacted for updated earnings information if the employee files an ICI claim.	Premiums are adjusted as of the first day of the month on or after date the change in percentage of appointment is effective.
Promotion, demotion or reclassification.	No change in coverage level or premium until next annual review period.	Not Applicable.	Not applicable – coverage is continuous.

304 Instructions for Completing the Evidence of Insurability (EOI) Application

The *Evidence of Insurability Application (ET-2308)* provides additional opportunities for employees to enroll for ICI coverage if coverage was previously declined, cancelled, lapsed or denied. It also provides a method by which employees may enroll after missing the initial enrollment period or if they wish to elect a shorter elimination period.

Employer and employee responsibilities for completion of the *Evidence of Insurability Application* are as follows:

A. Employer Responsibilities:

1. Review the ICI eligibility criteria outlined in subchapter 200 to determine the employee's eligibility.
2. Provide the employee with a copy of the *Income Continuation Insurance - Local (ET-2129)* brochure explaining the ICI Program.
3. Complete the employee's Social Security number, current employer, employer number 69-036- (XXXX-XXX), occupation and the date eligible for WRS. Forward the application to the employee for completion.
4. Instruct the employee to complete the *Evidence of Insurability Application (ET-2308)* according to the instructions. Incomplete applications will be returned to the employee, resulting in a delay of the application processing procedure.

B. Employee Responsibilities:

1. Complete the *Evidence of Insurability Application (ET-2308)*, including signature and date.
2. Submit the application **directly to ETF** no later than 30 days after completion to ensure current medical information. Applications received more than 30 days after the employee signs the application will be rejected. The employee will then be required to complete and submit a new application.
3. The employee is responsible for the cost of any medical exam or copies of the medical records.

C. Approval/Denial:

ETF will notify both the employee and the employer of approval or denial of ICI coverage approximately 60 to 90 days after ETF receives the *Evidence of Insurability Application (ET-2308)*.

For approved applications:

1. The effective date of coverage will be the first of the month on or after the date the EOI application is approved.
2. Premiums are due from that day forward.

For denied applications:

1. Retain the employer's copy of the denial form. Additional action by the employer is not necessary.
2. The employee has the right to request reconsideration of the initial denial by submitting a written request to the Third Party Administrator within 90 days of the date of the initial denial.

3. The employee has the right to request a subsequent review of the reconsideration's denial by requesting a Departmental Determination within 90 days of that denial.
4. A new application will not be considered until one year elapses from the date of initial denial.