

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

EMPLOYER RESOLUTION TO PAY ENTIRE PREMIUM FOR:

Check box(es):

- Basic Group Life Insurance
- Supplemental Group Life Insurance
- Additional Group Life Insurance
 - Unit 1
 - Units 1 & 2
 - Units 1, 2, & 3
- Spouse and Dependent Group Life Insurance

I hereby certify that pursuant to Wis. Stat. 40.05 (6)(e), a resolution to pay the entire group life insurance premium for all employees for the plan(s) indicated above was duly made by the

_____ (Governing Body)

of the _____ (Employer Name)

Employer Identification Number (EIN): 69-036- _____ on

_____ (Date Action Taken)

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

Date (MM/DD/CCYY)	WRS Agent Signature	Title
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(For ETF use only)

Effective Date of Coverage entered by ETF: