

**WISCONSIN PUBLIC EMPLOYERS GROUP LIFE INSURANCE PROGRAM  
INSTRUCTIONS FOR COMPLETION OF EVIDENCE OF INSURABILITY APPLICATION**

Group Life Insurance  
§40.70 (6)

Employees who did not enroll during their initial enrollment period, or insured employees who wish to apply for more insurance for themselves or their spouse/domestic partner or dependents, may apply using this Evidence of Insurability form. This application must be received by Securian Financial Group, Inc. (Securian) during the employee's active employment and prior to the date the applicant reaches age 70. Active employees who are turning age 70 and do not have Additional coverage, or new employees age 70 or over may apply for Additional coverage using this form. Employees age 70 or over do not need to have Basic coverage to apply for Additional coverage.

**EMPLOYER:**

1. Review the eligibility criteria outlined in the *Life Insurance Employer Administration Manual* (ET-1117), and the cover sheet of this application.
2. Determine the plan(s) for which the employee may enroll.
3. Complete the Employer Information section of the application.
4. Instruct the employee to complete the form and to make a photocopy for his or her records before submitting to Securian.
5. Securian will send you a written notice regarding the final outcome of this application.

**EMPLOYEE:**

1. Your employer must complete the Employer Information section of this application.
2. Review the Plan Booklet (ET-2101) and the cover sheet of this application for information about the plans you wish to apply for.
3. Complete both sides of the application.
4. If you are applying for insurance for yourself:
  - a) complete the boxes for the employee's height, weight, date of birth and gender.
  - b) answer the health questions using the "Employee" check boxes.
5. If you are applying for insurance for your spouse/domestic partner:
  - a) your spouse/domestic partner must complete the boxes for their height, weight, date of birth and gender.
  - b) your spouse/domestic partner must answer the health questions using the "Spouse/Domestic Partner" check boxes.
6. If you are applying for insurance for your dependent children, they do not need to be underwritten. Dependent children will automatically be covered upon the approval of your spouse/domestic partner. If you do not have a spouse/domestic partner, your dependent coverage will automatically be approved upon receipt of this completed application.
7. If your answer is "Yes" to any of the health questions, please provide details by completing the Health Information section on the reverse side of the form.
8. Sign and date the form at the bottom of the front side. Your spouse/domestic partner must also sign the form if applying for Spouse and Dependent Coverage.
9. Make a photocopy of the completed form for your records.
10. Mail the original completed form directly to:

Securian Financial Group, Inc.  
P.O. Box 259708  
Madison, WI 53725-9708

This application must be received by Securian no later than 90 days from the date signed to ensure medical information is current.

You and your employer will receive a report of action after insurability has been determined.

## WISCONSIN PUBLIC EMPLOYERS GROUP LIFE INSURANCE PROGRAM Plan Summary

The Wisconsin Public Employers (WPE) Group Life Insurance program offers employee coverage of up to five times your annual earnings. All five levels of insurance are available to state employees. The amount of coverage available to local government employees depends on which plans are offered by your employer. The following is a summary of the life insurance coverage that is available.

### Coverage Options

The **Basic Plan** provides coverage equal to your earnings for the previous year, rounded up to the next \$1,000.

The **Supplemental Plan** provides coverage equal to your earnings for the previous year, rounded up to the next \$1,000.

The **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your earnings for the previous year, rounded up to the next \$1,000. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of Additional coverage.

The **Spouse & Dependent Plan** provides coverage for your spouse/domestic partner and all dependent(s). If you elect one unit of coverage, your spouse/domestic partner will have \$10,000 in coverage and each dependent (regardless of the number) will have \$5,000 in coverage. If you elect two units, your spouse/domestic partner will have \$20,000 in coverage and each dependent will have \$10,000 in coverage.

### Amount of Coverage

The following is an example of how the amount of employee coverage is determined for an employee who chooses Basic, Supplemental and 3 Units of Additional coverage. The employee's previous year earnings are \$53,200. The earnings rounded up to the next thousand equals \$54,000 of coverage. The employee has coverage as follows:

Basic: (1x earnings) = \$54,000  
Supplemental: (1x earnings) = \$54,000  
Additional (3 units): (3x earnings) = \$162,000  
Total Amount of Insurance Coverage: (5x earnings) = \$270,000

### Effective Date of Coverage

The effective date for coverage approved under Evidence of Insurability is the first of the month following the date the application is approved by Securian.

**Evidence of Insurability Application  
Wisconsin Public Employers Group Life Insurance Program**

Wis. Stats §40.70(6)

Securian Financial Group, Inc.  
Minnesota Life Insurance Company  
Securian Life Insurance Company, a New York authorized insurer  
P.O. Box 259708 • Madison, WI 53725-9708



**EMPLOYEE INFORMATION**

Name (last, first, middle initial)

|                        |               |               |          |
|------------------------|---------------|---------------|----------|
| Social Security number | ETF member ID | Date of birth |          |
| Street address         | City          | State         | Zip code |

**EMPLOYER INFORMATION - To be completed by employer.**

|                                  |   |                                  |
|----------------------------------|---|----------------------------------|
| Current employer name            | Employer identification number<br>69 - 036 -  | Unit number                      |
| Date of hire at current employer | WRS annual earnings <input type="checkbox"/> Actual<br><input type="checkbox"/> Estimated | Amount of insurance (if insured) |

**INSURANCE DESIRED - Check only the plans you are applying for. Basic insurance is a prerequisite to all coverages except for employees age 70 or over selecting Additional coverage.**

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Basic Plan</b> (1x earnings)        | <b>Spouse &amp; Dependent Plan</b><br>(check only one box below)                            |
| <input type="checkbox"/> <b>Supplemental Plan</b> (1x earnings) | <input type="checkbox"/> 1 Unit (Spouse/Domestic partner = \$10,000; Dependent = \$5,000)   |
|   | <input type="checkbox"/> 2 Units (Spouse/Domestic partner = \$20,000; Dependent = \$10,000) |

**Additional Plan**

(check only one box below)

- 1 Unit (1x earnings)  
 2 Units (2x earnings)  
 3 Units (3x earnings)

If you are applying for the Spouse & Dependent Plan, please check one:

- I have a spouse/domestic partner and dependent children.\*  
 I currently have no spouse/domestic partner, but I do have eligible dependents.  
 I currently have no eligible dependents, but I do have a spouse/domestic partner.

\*If approved for Spouse and Dependent coverage, dependent children are automatically insured under this plan.

**SIGNATURE - Please read and sign below.**

Upon approval of this application, I hereby authorize payroll deduction from my earnings. I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance company, or employer who has any records or knowledge of me or my physical or mental health, or that of my dependent children, to give such information and any other nonmedical information to Securian ("Company") or its authorized representative. This shall include information as to my medical history, consultations, diagnosis, prescriptions or treatment, tests, and information as to alcohol, drug abuse or sickle cell disease.

The answers provided on this application are representations of each person signing below. The answers given are true and complete. It is understood that the Company shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

|  |                          |             |
|--|--------------------------|-------------|
| Employee signature<br>X  | Daytime telephone number | Date signed |
| Spouse/domestic partner signature (Required if applying for Spouse and Dependent Insurance)<br>X |                          |             |
| Print spouse/domestic partner name   |                          |             |

|  |   |                          |             |
|--|---|--------------------------|-------------|
| Is your spouse/domestic partner also applying separately as an employee for coverage under this program? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Daytime telephone number | Date signed |
|--|---|--------------------------|-------------|

**PROVIDE ADDITIONAL HEALTH INFORMATION ON REVERSE SIDE**

|               |                        |
|---------------|------------------------|
| Employee name | Social Security number |
|---------------|------------------------|

**HEALTH INFORMATION - Provide the following information only for those that apply.**

| EMPLOYEE |        |               |   | SPOUSE/DOMESTIC PARTNER |        |               |   |
|----------|--------|---------------|---|-------------------------|--------|---------------|---|
| Height   | Weight | Date of birth | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F | Height                  | Weight | Date of birth | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F |

Please answer the following health questions for all applicants. If your answer to questions 1, 2 or 3 below is "yes", provide details including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment under Additional Health Information section below.

| EMPLOYEE                 |                          | SPOUSE/DOMESTIC PARTNER  |                          | HEALTH QUESTIONS  |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| YES                      | NO                       | YES                      | NO                       |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you been diagnosed by a member of the medical profession as having AIDS or ARC?   |

**ADDITIONAL HEALTH INFORMATION - Specify by name if information is for employee or spouse/domestic partner**

| NAME | RELATIONSHIP TO EMPLOYEE<br>(self, spouse/<br>domestic partner) | DATE | NAME AND ADDRESS OF<br>DOCTOR, CLINIC, HOSPITAL | REASON FOR<br>CONSULTATION | DIAGNOSIS AND<br>TREATMENT |
|------|---|------|---|----------------------------|----------------------------|
|      |   |      |   |                            |                            |
|      |   |      |   |                            |                            |
|      |   |      |   |                            |                            |
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|      |   |      |   |                            |                            |
|      |   |      |   |                            |                            |

**REPORT OF ACTION - For Insurance Company Use**

|   |  |   |
|---|--|---|
| Basic: _____<br><input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Decl. incom.<br>By _____      | Supplemental: _____<br><input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Decl. incom.<br>By _____  | Total amount of insurance:<br>Employee:<br>_____    |
| Additional: _____<br><input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Decl. incom.<br>By _____ | Spouse & Dependent: <input type="checkbox"/> 1 Unit <input type="checkbox"/> 2 Units<br><input type="checkbox"/> Appr'd <input type="checkbox"/> Decl. <input type="checkbox"/> Decl. incom.<br>By _____ | Spouse/domestic partner and/or dependents:<br>_____ |