

**INCOME CONTINUATION INSURANCE APPLICATION**

<b>I. EMPLOYEE: COMPLETE PART I</b> TYPE OR PRINT IN INK, SIGN, AND RETURN TO EMPLOYER						Member ID
Name	Last	First	Middle I.	Maiden/Former	Social Security Number	
	Street No.		Street Name		Birthdate (MM/DD/CCYY)	
Address	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><b>1. ICI COVERAGE</b></p> <p>Check One</p> <p><input type="checkbox"/> I elect ICI coverage and authorize payroll deductions for premiums. <i>If your annual earnings exceed \$64,000.00, go to #2. If not, proceed to #3.</i></p> <p><input type="checkbox"/> I do not elect ICI coverage. <i>Sign below at #4.</i></p> <p><input type="checkbox"/> I wish to cancel my ICI coverage. (Checking this box also cancels Supplemental ICI coverage, if in effect.) <i>Sign below at #4.</i></p>					<p><b>2. SUPPLEMENTAL ICI COVERAGE:</b> Only available to employees whose annual earnings exceed \$64,000.00 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. <i>If you elected ICI coverage in #1, go to #3. If you already have ICI coverage, sign below at #4.</i></p> <p><input type="checkbox"/> I do not elect Supplemental ICI coverage. <i>If you elected ICI coverage in #1, go to #3. If not, sign below at #4.</i></p> <p><input type="checkbox"/> I wish to cancel my Supplemental ICI coverage. <i>Sign below at #4.</i></p>
<b>3.</b>	I elect the following calendar day elimination period for ICI coverage and Supplemental ICI coverage (if applicable): <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					

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.

<b>Sign and Return to Employer</b>	Signature of Employee	Telephone Number (    )	Date (MM/DD/CCYY)
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**Return to employer**

<b>II. EMPLOYER: COMPLETE PART II</b>	
Reason to submit <i>application</i> (Check appropriate box and indicate occurrence date)	<b>Previous Service - Complete Information</b>
<input type="checkbox"/> Immediately eligible on:	1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reinstating coverage upon return from temporary layoff or leave of absence. Date temporary layoff/LOA began: _____ Date employee returned: _____	2. Previous service check, completed <input type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service <input type="checkbox"/> ONE Site <input type="checkbox"/> ETF
<input type="checkbox"/> Changed to a longer elimination period effective on: (Evidence of insurability is required to change to a shorter elimination period.)	3. Date WRS participation began with the current employer (MM/DD/CCYY)
<input type="checkbox"/> Other (specify): _____	

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

Copy and Distribute:  ETF  Employee  Employer

