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

Group Life Insurance

REQUEST FOR DISABILITY PREMIUM WAIVER

Wis. Stat. § 40.72

Claim Number	
Plan A —	Dept./Unit

Name *(Last, First, Middle, Maiden)*		
Address *(Street and No.)*	Social Security Number	
(City, State and Zip Code)	Birthdate *(MM/DD/CCYY)*	Sex ☐ Male ☐ Female
Employer Name	Employer Number 69-036-	

Last Day Worked *(MM/DD/CCYY)*	Last Day for Which Paid *(MM/DD/CCYY)*	Continue to collect and submit premium until you receive notification that the premium waiver is approved.	Status

Has employee terminated employment?
☐ Yes (Date of termination __________________) ☐ No

If yes, is the termination due to an apparent disability? ☐ Yes ☐ No

Is the employee on a leave of absence (LOA)?
☐ Yes (Date LOA commenced _______________) ☐ No

If yes, is the employee expected to return from LOA?
☐ Yes ☐ No ☐ Unknown

Description of Disability *(if known)*

Coverage Based on:

Year of highest full calendar year earnings: ____________

Amount of highest earnings: $______________

Amount of coverage: $___________
(Highest earnings rounded to next 1000)

TYPE:	Effective Date of coverage
Basic	______________________
Supplemental	______________________
Additional 1	______________________
Additional 2	______________________
Additional 3	______________________
S/D I	______________________
II	______________________

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.

Date *(MM/DD/CCYY)*	Signature of Employer Representative	Telephone Number
Employer Address *(Street and No., City, State and Zip Code)*		

To the Employer: File this form whenever you first become aware that an insured employee is unable to work due to illness or injury and will be unable to perform any work or to engage in any occupation for an indefinite period. You are not required to make a medical determination or evaluate the individual's potential for vocational rehabilitation or retraining. The employee will be required to submit medical evidence to the insurance company that demonstrates a total disability.

This form must be filed within 36 months after the last day for which earnings were paid. Insured employees who are on layoff status or on leave for non-medical reasons are eligible if they become disabled during the leave. Employees who have terminated employment are eligible only if the onset of the disability occurred prior to termination. Employees who become disabled while on a union service leave of more than 36 months' duration are not disqualified from receiving a waiver of premium after 36 months. **Life insurance coverage must be in force at the time the employee becomes disabled.**

Effective Date: If approved, the premium waiver will take effect beginning with the first of the month following the date of the onset of disability or the last day for which earnings were paid, whichever is later.

Make a copy for your records.