

Department of Employee Trust Funds (ETF)
INCOME CONTINUATION INSURANCE (ICI)
EMPLOYER STATEMENT

Wis. Stat. § 40.61 and 40.62

Employee Name
Social Security Number
Employer Identification Number

INSTRUCTIONS TO EMPLOYER:

The employee named below is applying for an ICI benefit. Please follow the detailed instructions on the back of this form and return it to the Department of Employee Trust Funds (ETF) promptly. Benefits cannot be computed until this form is received and processed.

Occupation (Title) _____ <input type="checkbox"/> Seasonal/Academic Yr <input type="checkbox"/> Permanent <input type="checkbox"/> Project <input type="checkbox"/> LTE <input type="checkbox"/> Per Diem	<input type="checkbox"/> Previous Calendar Years Salary <input type="checkbox"/> Projected Salary: <input type="checkbox"/> New Hire <input type="checkbox"/> Change in Appointment <input type="checkbox"/> Change in Hourly Rate*	Last Day Worked <i>(MM/DD/CCYY)</i> _____	Last Day Paid <i>(MM/DD/CCYY)</i> _____								
Monthly Salary <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time \$_____ Part Time Percent _____%	Has claim been filed for Worker's Comp? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Denied <input type="checkbox"/> Pending	Worker's Comp. Effective Date _____ Paid Thru _____	Weekly Worker's Comp Amount \$_____								
(State Only) Total Sick Leave Shown to hundredths of an hour—2 Decimal Places Accumulated Hrs _____ Earned Hours _____ Total Hours _____	(State Only) Date Sick Leave is Exhausted <i>(MM/DD/CCYY)</i> _____	Premium Category/Elimination Period <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border-bottom: 1px solid black;">Year</td> <td style="width: 25%; border-bottom: 1px solid black;">Year</td> <td style="width: 25%; border-bottom: 1px solid black;">Year</td> <td style="width: 25%; border-bottom: 1px solid black;">Current Year</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		Year	Year	Year	Current Year	_____	_____	_____	_____
Year	Year	Year	Current Year								
_____	_____	_____	_____								
(UW-Faculty Only) Elimination Period- Calendar Days <input type="checkbox"/> 30 <input type="checkbox"/> 90 <input type="checkbox"/> 125 <input type="checkbox"/> 180	(Locals Only) Elimination Period-Calendar Days <input type="checkbox"/> 30 <input type="checkbox"/> 90 <input type="checkbox"/> 125 <input type="checkbox"/> 180	Premiums are Paid Through <i>(MM/DD/CCYY)</i> _____									
(Locals Only) Percentage of Premium Paid by Employer in Prior Years:											
20 _____ _____%	20 _____ _____%	20 _____ _____%	Current Year _____%								
Claimant has elected the supplemental ICI Coverage. <input type="checkbox"/> Yes <input type="checkbox"/> No											
(State Only) Claimant Has Elected To: <input type="checkbox"/> Use a Max. of 130 Days of Sick Leave <input type="checkbox"/> Bank All Sick Leave After: _____ <i>(MM/DD/CCYY)</i>											
Employer <i>(Circle: State or Local)</i>	Division <i>(State)</i>	Central Payroll Code Number <i>(State)</i>									
I understand Wis. Stat. § 943.395 provides 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 <i>(MM/DD/CCYY)</i>	Authorized Employer Signature										
Employer contact e-mail address:			Employer Telephone No. ()								

Date Sent to Employer:	Sent by:	Telephone Number:
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Employer Instructions

1. Complete this form as quickly as possible and e-mail to this address: ETFWEB@etf.state.wi.us. If you are unable to e-mail it please fax to ETF at (608)267-4549 OR send it by mail to the address on page 1. No ICI benefits are payable to your employee until the completed form (and required medical) is received and processed.
2. For State or Local employees, report the last day paid for any vacation, holiday or compensatory time paid after the elimination period. For Local employees only, report last day paid for any sick leave paid in addition to any vacation, holiday or compensatory time paid after the elimination period.
3. Monthly Salary –
To determine benefits as of the date of disability, the average monthly salary is determined by using the:
 - Previous calendar year salary, rounded to the next higher thousand and divide by 12.
OR
 - If there is a new hire or a permanent change in appointment, estimate the base salary (including add-ons for certain educational degrees, certifications, licenses or credentials) to be received during the ensuing 12 months. Round to the next higher thousand and divide by 12.

* **NOTE:** If the employee has received a permanent change in the hourly rate (and is not a new hire or did not have a change in appointment), report the higher of:

 - Previous calendar year salary. OR
 - Projected salary.
4. For **State** employees, report the accumulated sick leave hours as of the employee's last day worked, plus any additional sick leave earned while continuing in pay status. Report sick leave in hours and hundredths of hours (2 decimal places), **not minutes**.
5. For most **State** employees who work a standard Monday – Friday work week, sick leave is not utilized on paid legal holidays and thus extends the date sick leave is exhausted.
6. For **State** employees, an ICI claimant who has applied for a Wisconsin Retirement System disability, Long Term Disability Insurance (LTDI) benefit, or duty disability benefit may convert (bank) sick leave to pay for health insurance premiums and begin ICI benefits at an earlier date. Determine, with the employee, the date through which sick leave is to be used. If the permanent disability is not approved, the date through which sick leave was used will have to be adjusted. Attach written documentation to this form, which verifies the employee's decision to bank sick leave after a specified date.
7. Continue to collect premiums, for eligible employees, until you receive written notice of approval of the claim. Note that no premiums can be accepted after employment is terminated.
8. Under "Premium Category," fill in the premium category or selected elimination period for the year in which the disability began (current year) as well as the previous three calendar years.
9. Indicate whether the employee is enrolled in the supplemental ICI coverage.
10. After completion, please make a copy of this form for your records for future reference.
11. Please include your e-mail address.