

STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
INCOME CONTINUATION INSURANCE FORMS/BOOKLETS ORDER
FORM

Employer Name: _____
EIN: 69-036- _____

Forms must be mailed to a street address.

Street Address: _____

Contact Name: _____

Contact Phone: _____

State & Local Employer Orders

Please indicate forms and quantity needed:

<u>Forms/Booklets</u>	<u>Quantity</u>
<input type="checkbox"/> ET-2106 ICI Booklet – State (rev 08/2007)	_____
<input type="checkbox"/> ET-2129 ICI Booklet – Local (rev 08/2007)	_____
<input type="checkbox"/> ET-2307 State ICI Enrollment Form (rev 02/2005)	_____
<input type="checkbox"/> ET-2366 Local ICI Enrollment Form (rev 02/2005)	_____
<input type="checkbox"/> ET-2308 ICI Evidence of Insurability (EOI) Enrollment (rev 04/2005)	_____
<input type="checkbox"/> ET-5901 ICI Transaction Report (rev 12/2004)	_____
<input type="checkbox"/> State Claim Packet (ET-2106, ET-5350 and ET-5352)	_____
<input type="checkbox"/> Local Claim Packet (ET-2129, ET-5350 and ET-5352)	_____
<input type="checkbox"/> ET-1119 State Employers ICI Administration Manual (rev 07/2005)	_____
<input type="checkbox"/> ET-1145 Local Employers ICI Administration Manual (rev 12/2004)	_____
<input type="checkbox"/> ET-1629 ICI Monthly Premium Report- Locals (rev 01/2005)	_____

Return to: AETNA Disability Workability

Fax: (866) 667-1987

PO Box 14560
Lexington, KY 40512-4560

Email: ICILTDI@aetna.com

Date Received at AETNA: _____

Date Processed: _____