Return to Work Form

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Employer: Complete, Sign and date below.
Make one copy for your records and one copy for your employee. Submit the original to ETF.

Employer name (if state of Wisconsin, include dept.)	ETF Employer ID 69-036-
ETF-administered insurance employer participation (applicable if WRS eligible) ☐ Health ☐ Life ☐ Supplemental Vision ☐ Supplemental Dental ☐ ICI	Enrollment date (MM/DD/YYYY)
WRS termination date	

Employee name (first, middle, last)	Birth date (MM/DD/YYYY)	ETF Member ID
WRS employment category	Hire date (MM/DD/YYYY)	

Is the person hired as a contractor? (Contractors complete one of the boxes below depending on WRS termination date. Third-party contractors must only sign and date the form below) ☐ Yes (Third-party) ☐ Yes (Independent) ☐ No

Agent: Sign here and send to ETF	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 certify that I am responsible for reporting coverage information to the Wisconsin Retirement System.		
	Signature and title of agent	Telephone	Date (MM/DD/YYYY)

Employee: Complete below, choose applicable insurance you want to enroll in.

Gender
☐ Male ☐ Female

Address (street, city, state, ZIP)

Insurance(s) You Want to Enroll In
(The options your employer offers are checked in the Employer section above. Contact your employer with questions.)

Health	☐ Yes ☐ No
Life	☐ Yes ☐ No
Supplemental Vision	☐ Yes ☐ No
Supplemental Dental	☐ Yes ☐ No
Income Continuation Insurance (ICI)	☐ Yes ☐ No

Authorization

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 certify that I am responsible for reporting coverage information to the Wisconsin Retirement System.

Employee: Sign Here	Employee signature	Date (MM/DD/YYYY)

Insurance Coverage

Only employees who are eligible for WRS participation and enrolled in the WRS are eligible for the insurances that the employer offers.

Employees electing to participate in WRS or mandatorily covered under the WRS due to 2013 WI Act 20 must be offered **all** ETF-administered insurance the employer offers. If annuitants are eligible for the WRS and want to participate in employer-sponsored insurance programs (health, life, ICI), they must indicate which coverages they want to elect in the employee section.

- The applications for chosen insurances should be attached and returned to ETF with this form. Check with your employer's benefits office or see the ETF website at etf.wi.gov/insurance for more information and forms.

Employee not insured
Employers must receive applications within 30 days following the WRS participation begin date. Insurances become effective the first of the month following receipt of the application by the employer. This applies to all ETF-administered insurance the employer offers.