Supplemental Insurance Application/Change

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

There are certain times throughout the year when you may enroll in supplemental insurance or change your coverage. Note that this form is only to enroll in supplemental benefits. See a health application, available at etf.wi.gov to enroll in or change your health insurance coverage. **If you are an active employee, return this completed form to your employer. Retirees and survivors, return this completed form to the Department of Employee Trust Funds. Print clearly.**

1. Applicant information

Only the subscriber applying for coverage should complete this form.

Name First	M.I.	Last	Former/Maiden (if applicable)

ETF ID	SSN	Telephone, inc. area code

Mailing address (Street)	City	State	ZIP code	Country

Email

Birth date (MM/DD/YYYY)	Sex	I am a/an:
	☐ Male ☐ Female ☐ Prefer not to answer	☐ Active employee ☐ Retiree or Survivor

2. Spouse Information

This section is not required for individual coverage.

Name First	M.I.	Last	Former/Maiden

SSN	Birth date (MM/DD/YYYY)	Sex
		☐ Male ☐ Female ☐ Prefer not to answer

Telephone, inc. area code	Email

3. Dependent Information

Do not include your spouse (add spouse information above). This section is not required for individual coverage.

Name *You may attach additional pages if more space is needed*			SSN	Birth date (MM/DD/YYYY)	Sex
First	*M.I.*	*Last*			
					☐ Male ☐ Female ☐ Prefer not to answer
					☐ Male ☐ Female ☐ Prefer not to answer
					☐ Male ☐ Female ☐ Prefer not to answer
					☐ Male ☐ Female ☐ Prefer not to answer
					☐ Male ☐ Female ☐ Prefer not to answer
					☐ Male ☐ Female ☐ Prefer not to answer
					☐ Male ☐ Female ☐ Prefer not to answer

4. Supplemental Plan Selection Select the plan(s) and coverage level you are enrolling in.

☐ Vision (DeltaVision)
☐ Individual ☐ Individual + Spouse ☐ Individual + Child(ren) ☐ Family

☐ Accident Plan (Securian Financial)
Only available to active employees
☐ Individual ☐ Individual + Spouse ☐ Individual + Child(ren) ☐ Family

☐ Preventive Dental Plan (Delta Dental PPO Plus Premier™)
Only available if not *enrolled in a health plan with dental*
☐ Individual ☐ Family

Supplemental Dental – select only one:

☐ Select Plan (Delta Dental PPO)
☐ Individual ☐ Individual + Spouse ☐ Individual + Child(ren) ☐ Family

☐ Select Plus Plan (Delta Dental PPO Plus Premier™)
☐ Individual ☐ Individual + Spouse ☐ Individual + Child(ren) ☐ Family

Local Wisconsin Public Employer employees: You can only enroll plans your employer offers. Check with your employer.

5. Reason for enrollment/change?

☐ New subscriber (*select option below*). Wisconsin Retirement System enrollment date: _____
☐ New hire
☐ Rehire
☐ Annual open enrollment

☐ Eligible life event change (*select option below*). Life change event date: _____
☐ Birth / Adoption ☐ Marriage
☐ Divorce ☐ Loss of Other Coverage (*select option below*)

If you check "Lost of Other Coverage" above, which coverage was lost? (*Documentation will be required*)
☐ Vision ☐ Accident ☐ Dental

☐ Group Transfer **(State only)**

From: _____ To: _____ Date Occurred: _____

State Transfering Employees: You are limited to previous coverage and can make changes or cancel only with an eligible life change event or during the annual open enrollment period.

6. Cancel Coverage can only be canceled during the annual open enrollment period without an eligible life event.

Select the coverage(s) you would like to cancel, and the reason why.
Cancel:
☐ Vision
☐ Accident
☐ Delta Dental PPO Plus Premier™ – Preventive Plan
☐ Delta Dental PPOTM – Select Plan
☐ Delta Dental PPO Plus Premier™ – Select Plus Plan

Reason for canceling:
☐ Eligible life event change (Also select the eligible life event change and list date in Section 5, above.)
☐ Annual open enrollment - Date: _____
☐ Gain comparable coverage - Date: _____

Name: _____ ETF ID: _____

7. Change dependent coverage Dependents can only be *removed* during the annual open enrollment period without an eligible life event.

Select the reason you are changing dependent coverage, and list the dependent name(s) to add or remove below.

☐ Eligible life event change (Also select the eligible life event change and list date in Section 5, above.)

☐ Annual open enrollment - Date: _____

☐ Gain comparable coverage - Date: _____

☐ Add new dependent(s):

Name: _____

Name: _____

☐ Remove current dependent(s):

Name: _____

Name: _____

8. Personal Information Changes Leave blank if no changes needed

☐ Name change.

Former name: _____ Date of change :_____

☐ Address change.

Previous address: _____ Date of change: _____

9. Billing

Active Employees: Your employer will set up payroll deduction to pay for coverage. Submit your completed application to your employer.

Retirees or Survivors: If enrolling in a Supplemental Dental or Vision plan, only choose **one** payment option:

☐ Direct Bill – Paper Invoice

☐ WRS Annuity Deduction

10. Subscriber Signature *Required* If not signed, ETF cannot accept your application

By signing this application, I apply for the insurance under the indicated supplemental insurance contract made available to me through the State of Wisconsin. A copy of this application is considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. Providing false information is punishable under Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Subscriber signature	Date signed (MM/DD/YYYY)

If you are an **active employee**, return this completed form to your employer. Premiums will be deducted from your payroll.

If you are enrolling in or changing **retiree or survivor benefits**, return this completed form to ETF. Supplemental Dental and Vision insurance premiums will be deducted from your monthly annuity *if you qualify* and select the WRS Annuity Deduction option in the Billing section, above. Premiums will be paid directly to the vendor if you *do not qualify* for annuity deductions *or* if you choose to receive a paper bill from the vendor in the Billing section above.

Employer must review the completed application before completing the employer section on the next page.

Name: _____ ETF ID: _____

Employer Completes – complete entire section, including the signature

Employer must review the completed employee application before filling out and signing this section.
If this section is not completed by the employer for their active employees, ETF cannot accept the application.

EIN	Employer name		Payroll representative email
Business Unit (*if applicable*)	Hire date or date of eligibility	Supplemental plan name(s)	
Employee Type	Employment status of applicant ☐ Full time ☐ Part time ☐ LTE**		Employee deductions* ☐ Pre-tax ☐ Post-tax
Employer received date	Event date	Employer Telephone, including area code	
Payroll representative signature			Date signed (MM/DD/YYYY)

*Supplemental Dental and Vision Plan deductions must be Pre-tax *unless employee chose otherwise on ET-2340*. Accident Plan premiums must be deducted post-tax.

**State LTEs must have all supplemental insurance premiums deducted post-tax.