# Resolution for Inclusion Under Group Life Insurance

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

RESOLVED, by the _____ of the _____ of _____
Governing body Employer legal name

that pursuant to the provisions of Chapter 40 of the Wisconsin Statutes such _____
Governing body

hereby determines to be included under the following Group Life Insurance program(s) provided by Chapter 40 of the Wisconsin Statutes for its eligible personnel:

Check box(es) for coverage desired:

- ☐ Basic Group Life Insurance (1x earnings)
- ☐ Supplemental Group Life Insurance (1x earnings)
- ☐ Additional Group Life Insurance
  - ☐ 1 Unit (1x earnings)
  - ☐ 2 Units (2x earnings)
  - ☐ 3 Units (3x earnings)
- ☐ Spouse and Dependent Group Life Insurance
- ☐ Amount of insurance for any insured employee who attains age 65 on or after the effective date of this resolution shall be 50% rather than 25%

BE IT FURTHER RESOLVED, that the proper officers are herewith authorized and directed to take all actions and make such deductions and submit such payments as are required by the Group Insurance Board of the State of Wisconsin to provide such group life insurance.

BE IT FURTHER RESOLVED, that the _____ WRS Agent submit a certified copy of this
Employer name
resolution to the State of Wisconsin Department of Employee Trust Funds.

**Certification**

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the _____ of the _____ of _____on the
Governing body Employer name
____ day of _____, and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this ____ day of _____.

I understand that Wis. Stat. 943.395 provides criminal penalties for knowingly making false and fraudulent statements on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct.

Employer Identification Number (EIN) **69-036-**_____ Number of eligible employees: _____

WRS agent signature: _____ WRS agent title: _____

Mailing address: _____

Telephone: _____

Email: _____

*For ETF use only*
EFFECTIVE DATE OF COVERAGE ENTERED BY ETF:

The resolution shall be effective on the first of the fourth month after receipt in the office of the Department of Employee Trust Funds. Submit completed form to ETF at ETFSMBESSNewEmployer@etf.wi.gov or fax to 608-267-4549.