Resolution for Inclusion Under the Wisconsin Public Employers' Group Health Insurance Program

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 _____
(Governing Body) (Employer Legal Name)
that pursuant to the provisions of Wis. Stat. § 40.51 (7) hereby determines to offer the Wisconsin Public Employers (WPE) Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board (Board), and agrees to abide by the terms of the program as set forth in the *Local Employer Health Insurance Standards, Guidelines and Administration Manual* (ET-1144).

All participants in the WPE Group Health Insurance Program will need to be enrolled in a program option. An employer may elect participation in program options listed below, **with each program option to be offered to different employee classifications (pursuant to collective bargaining). Individual employees cannot choose between program options**.

We choose to participate in the (check applicable options):

- ☐ Traditional HMO-Standard PPO W/ Dental, P02
- ☐ Deductible HMO-Standard PPO W/ Dental, P04
- ☐ Coinsurance HMO-Standard PPO W/ Dental, P06
- ☐ High Deductible Health Plan HMO-Standard HDHP PPO W/ Dental, P07
- ☐ Traditional HMO-Standard PPO W/O Dental, P12
- ☐ Deductible HMO-Standard PPO W/O Dental, P14
- ☐ Coinsurance HMO-Standard PPO W/O Dental, P16
- ☐ High Deductible Health Plan HMO-Standard HDHP PPO W/O Dental, P17

Send resolution(s) to:
Department of Employee Trust Funds
Division of Insurance Services
PO Box 7931
Madison WI 53707-7931

or

ETFSMBESSNewEmployer@etf.wi.gov

The large group (50 or more employees) underwriting and enrollment process takes 120 days. (Small groups of 49 or less employees do not go through underwriting and take 60 days.) All groups are eligible to enroll effective January 1, April 1, July 1, or October 1.

RESOLUTION EFFECTIVE DATE: (select one date):_____

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the Board to provide such Group Health Insurance.

CERTIFICATION

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regularly passed by the above governing body on the ____ day of _____, year _____ and that said resolution has not been repealed or amended, and is now in full force and effect.

☐ I further certify that we offered insurance to our employees immediately prior to joining this program.

Dated this ____ day of _____, year _____.

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

Federal tax identification number (FEIN/TIN)

Authorized employer representative signature

69-036-
ETF employer identification number

Authorized employer representative printed name

Number of eligible employees _____

Authorized representative title

Employer county

Employer benefit contact email address

Mailing address

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