Income Continuation Insurance Application

State Employee
Wis. Stat. § 40.61

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

☐ This form is being submitted due to an employer error.

Refer to the *Income Continuation Insurance Administration Manual — State* (ET-1119) for instructions.

Employee Information Type or print in ink. Sign and return to *employer*. Employer: Complete page 2.

Name (first, middle, last, former/maiden)		
Birth date (MM/DD/YYYY)	Member ID	Social Security number
Address (street)		
City State ZIP code Country and Mail Code (if not USA)		Sex ☐ Male ☐ Female

1. Income Continuation Insurance (ICI) coverage. *Check one:*

☐ I elect ICI coverage and authorize payroll deductions for premiums.

☐ I do not elect ICI coverage. *Sign below.*

☐ I wish to cancel my ICI coverage. Cancellation is effective the first day of the month which occurs on or after the date the application is received. *Sign below.*

2. I was most recently employed by the following state agency: _____

From *(MM/DD/YYYY)* _____ to *(MM/DD/YYYY)* _____

University of Wisconsin faculty/academic staff only, complete this section
(excludes employees of the University of Wisconsin Hospitals and Clinics)

Elect calendar day elimination period for ICI coverage:
☐ 30-day ☐ 90-day ☐ 125-day ☐ 180-day

I want my coverage to be effective: ☐ As soon as possible
☐ When the UW contributes toward premium *(defer coverage for up to 12 months)*

Sign and Return to Employer

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 authorize the monthly employee share premium deduction (indicated below) from my earnings to provide ICI coverage. I understand that if premiums are not deducted, I do not have ICI coverage.

Employee signature	Date	Telephone, including area code

Submit this completed form to your employer. Your employer will complete the next page and then submit to ETF.

This page is for the employer to complete.
Refer to the *Income Continuation Insurance Administration Manual — State* (ET-1119) for instructions.

Application Information (To be completed by Employer)

Date application provided to employee: _____

Date received from employee: _____

Reason to submit application—check one box and list date event occurred:

- ☐ Began WRS participation with current employer on: _____
- ☐ Reinstating coverage upon return from temporary layoff or leave of absence.
  Date temporary layoff or leave of absence began: _____ Date employee returned: _____
- ☐ Transferred from another state agency on: _____
- ☐ Eligible through deferred coverage on: _____
- ☐ Enrollment through employer error provision
  Note: More information available in chapter 10 of the ICI administration manual (ET-1119).
- ☐ Other (specify): _____

UW Faculty/Academic Staff only (*not* applicable to UWHC Employees):

- ☐ Changed to a longer elimination period effective on: _____
  (Evidence of insurability is required to change to a shorter elimination period.)

UW Faculty/Academic Staff only (*not* applicable to UWHC Employees):

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check, completed? ☐ Yes ☐ No
3. Source of previous service? ☐ ONE Site ☐ ETF

Annual Earnings *(Rounded up to the next higher thousand.)*

$

**Refer to Chapter 3 of the ICI Administration Manual (ET-1119) for instructions on determining annual earnings amount to use.*

Basis of employment

- ☐ Full time
- ☐ Part-time: _____%
- ☐ Seasonal
- ☐ Academic
- ☐ Project
- ☐ LTE

Sick Leave Information for Deferred Coverage or Reinstated or Rehired Employees

Total accumulation of sick leave credits for the preceding two calendar years:

Year	Beginning balance	Sick leave earned	Sick leave used	Ending balance

Employer Information

Employer name	EIN 69-036-	
Employer agent signature	Telephone, including area code	Effective date

Copy and distribute: ☐ ETF ☐ Employee ☐ Employer