Evidence of Insurability Instructions

Income Continuation Insurance
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

The *Evidence of Insurability* application allows you to apply to enroll in the Income Continuation Insurance (ICI) Program if you did not enroll when originally eligible (open enrollment period) or if coverage was canceled. This includes faculty and academic staff at the University of Wisconsin and local employees who wish to change to a shorter waiting period. You are responsible for the cost of any medical examination(s).

In order to be approved, you must demonstrate good health satisfactory to the plan administrator and **must have been seen by a physician for a physical examination no more than 12 months prior to the date the application is submitted**.

The insurance coverage effective date shall be the first day of the calendar month which begins on or after the date the application is approved.

Complete the form in its entirety to ensure timely processing of your application. **Answer all questions completely.** If a question is not answered or a question is not answered completely, the form will be returned to you.

Enter the date you completed the application. Your completed application must be received by the Department of Employee Trust Funds no later than one month from this date in order to ensure current medical information.

Your signature is required.

Mail the completed application directly to:

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

ETF will notify you and your employer of denial or approval and the effective date of coverage, if applicable.

Personally identifiable information, such as your Social Security number, date of birth, etc., will not be used for any purpose other than for the administration of the benefit programs administered by ETF.

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First MI Last

Street Address or P.O. Box

City State ZIP Code

Social Security number:		
Date of birth (MM/DD/YYYY)		
Sex ☐ M ☐ F	Height ft. in.	Weight lbs.

- Have you ever applied through ICI Evidence of Insurability before? ☐ Yes ☐ No
- Are you applying to shorten your waiting period? ☐ Yes ☐ No

Current Employer or Department

Employer Number
69-036

UW Faculty and Academic Staff

I elect the following waiting period (calendar days):

☐ 30 day ☐ 125 day
☐ 90 day ☐ 180 day

Local Government Employees Only

I elect the following waiting period (calendar days):

☐ 30 day ☐ 90 day ☐ 180 day
☐ 60 day ☐ 120 day

Occupation	Date Eligible for WRS (MM/DD/YYYY)

Answer each of the following questions carefully and completely

	Yes	No
1. Are you presently in good health and free from physical impairment? If no, explain.	☐	☐
2. Are you currently on a leave of absence from your employer? (If yes, you are not eligible to apply at this time. Please apply when you return to work.)	☐	☐
3. Are you currently pregnant? (If yes, you are not eligible to apply at this time. Please apply when you are no longer pregnant.)	☐	☐
4. Has any life, health, or accident and sickness insurance application including income continuation insurance been canceled, rejected, or assigned to a special rate category because of your medical condition? If yes, explain.	☐	☐
5. Within the last five years, have you made a claim for, or received, disability or retirement payments because of an illness or injury? If yes, give date, amount, company, type of illness or injury, type of insurance, and reason.	☐	☐
6. During the last five years, have you been hospitalized, had surgery or been advised to have surgery? If yes, give date, hospital, doctor, and diagnosis.	☐	☐

7. Have you ever been diagnosed or received treatment by a health care provider or had reason to suspect you have had any of the following:

- ☐ Heart Disease/Attack
- ☐ Chest Pain, Angina, or Shortness of Breath
- ☐ Disorder of Heart Muscles, its Nerves or Vessels
- ☐ Irregular Heart Beat, Murmur or Rheumatic Fever
- ☐ Abnormal Blood Pressure
- ☐ Disorder of Veins or Arteries
- ☐ Diabetes, High or Low Blood Sugar
- ☐ Disorder of Kidneys or Bladder
- ☐ Venereal Disease, Syphilis, Gonorrhea, Genital Warts or Genital Herpes
- ☐ Protein, Blood or Sugar in Urine
- ☐ Night Sweats, Persistent Swollen Glands, or Diarrhea
- ☐ Arthritis, Bursitis or Gout
- ☐ Disorder of Back, Neck or Spine
- ☐ Disorder of Muscles, Bones or Joints
- ☐ Temperomandibular Joint Syndrome (TMJ)
- ☐ Recurrent Abdominal Pain or Hernia
- ☐ Stroke, Epilepsy or Seizure Disorder
- ☐ Migraine or Persistent Headaches
- ☐ Mental or Nervous Disorder
- ☐ Dizziness or Paralysis
- ☐ Asthma, Emphysema, Breathing or Lung Disorder
- ☐ Indigestion, Ulcers or Colitis
- ☐ Cancer of any Type, Past or Present
- ☐ Tumor or Cysts
- ☐ Conditions of the Brain or Nervous System
- ☐ Conditions of the Eyes, Ears, Nose or Throat
- ☐ Conditions of the Skin or Lymph Nodes
- ☐ Conditions of the Prostate, Ovaries or Uterus
- ☐ Conditions of the Stomach, Intestines, Gallbladder or Liver
- ☐ Conditions of the Thyroid or any Gland
- ☐ Treatment to limit use of Alcohol, Other Chemicals or Drugs
- ☐ AIDS or any Disorder of Immune System*
- ☐ Human Immunodeficiency Virus (HIV)*
- ☐ AIDS Related Complex (ARC)*

*You are not required to submit, nor are we seeking a result of an HIV Antibody Test.

8. If any of the above are checked, give date, nature and period of disability, doctor's name and address and result.

9. Physician who is most familiar with your medical history. Include physician's full name, address, city, state, ZIP.

Name:_____ Address:_____

Date last visited:_____ Reason for visit:_____

Other Physician(s) consulted within the last five years: (Add additional names and addresses on a separate sheet of paper, if necessary.)

Name:_____ Address:_____

Upon approval of this application I hereby authorize payroll deductions from my earnings. I hereby authorize any and all physicians, hospitals, clinics, etc. to release to the Wisconsin Department of Employee Trust Funds or the ICI Program Administrator information from my health record. I understand that the specific type of information to be released includes any and **all medical and/or treatment records, and may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testing and results, and/or treatment records**. This release is being made for the purpose of applying for insurance. A copy of this authorization shall be considered as effective and valid as the original and is effective for 90 days from the date signed below.

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, correct and complete.

Date (MM/DD/YYYY)	Signature	Telephone No., including area code Work: Home:

☐ _____ did not respond to several requests for additional medical information.

☐ The medical information received from _____

indicates _____Reapply:_____

Application: ☐ APPROVED ☐ DENIED Date: By:

For ETF only. Effective date of Coverage (MM/DD/YYYY):