Income Continuation Insurance Application

Local Government 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.** (Employers should refer to chapter 10 of *The Wisconsin Public Employers Income Continuation Insurance Administration Manual* (ET-1145) for more information on "employer error" submissions.)

Employee Information Type or print in ink. Sign and return to employer.

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 elect the following calendar day elimination period for ICI coverage:

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

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 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

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 Wisconsin Public Employers Income Continuation Insurance Administration Manual* (ET-1145) 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: _____
- ☐ Changed to a longer elimination period effective on: _____
  Note: Evidence of insurability is required to change to a shorter elimination period.
- ☐ Enrollment through employer error provision.
  Note: More information available in chapter 10 of the ICI administration manual (ET-1145).
- ☐ Other (specify):

  _____

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

$

**Refer to Chapter 3 of the ICI Administration Manual (ET-1145) for instructions on determining the annual earnings amount to use.*

Basis of employment

- ☐ Full time
- ☐ Part-time: _____%

Employer Information

Employer name	EIN 69-036-	
Employer agent signature	Telephone	Effective date / 01 /

Copy and distribute: ☐ ETF ☐ Employee ☐ Employer