Income Continuation Insurance (ICI) Claim Form

Wis. Adm. Code 40.61 and 40.62

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

Income Continuation Insurance (ICI) Claim Form Instructions

An ICI claim can be filed by paper using this form. However, filing by phone is greatly encouraged. To file by phone, call ETF's third-party administrator at 1-800-960-0052. For phone filing instructions, see *Claim Filing Instructions for Income Continuation Insurance (ICI) Benefits (*ET-5106).

If it is not possible to file a claim by phone, please submit this paper claim form as outlined below.

1. Complete *every* question on this *Income Continuation Insurance (ICI) Claim Form* (ET-5352) (which is on page 2 of these instructions) to avoid a delay in benefit payments.

2. The "Last day worked" is the last date you were physically at work.

3. The "First date disabled" is the first date you believe you were incapable of working.

4. The "Date first treated" is the first date you saw a physician.

   Note: Normally, the first day of your elimination period will be the day after the last day you worked. However, if your first date of treatment by a physician is after the last day you worked, the "Date first treated" will be the first day of your elimination period.

5. List all physicians, hospitals, clinics, therapists and other health care providers who have been involved in the treatment of your disabling condition since your last day worked (attach additional sheets of paper if necessary).

6. Send the *Income Continuation Insurance (ICI) Claim Form* (ET-5352) and **a copy of your current position/job description** to the Department of Employee Trust Funds as soon as possible **after your last day worked**. ICI benefits will not be paid for any time which is more than 90 days prior to the date ETF receives this claim form. No benefits will be paid if this claim form is received by ETF more than 12 months after the last day for which you were paid by your employer.

   A claim may be submitted up to 30 days prior to the last day worked in cases of scheduled surgery or impending childbirth.

Mail to: ETF, PO BOX 7931, MADISON WI 53707-7931

For further details about the ICI claim process, please see
Claim Filing Instructions for Income Continuation Insurance (ICI) Benefits (ET-5106).

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1. Claimant Information

Name *First*	*M.I.*	*Last*	ETF ID or Social Security number	
Former/Maiden (if applicable)		Birth date (MM/DD/YYYY)	Telephone ( )	☐ Male ☐ Female
Mailing address (Street)		City State ZIP code	Email	
Occupation (Title)		Classification	Employer/Agency	

2. Disability Information

What is the nature of your disability? Describe complications, if any.

Last day worked	First date disabled	Date first treated	Expected return-to-work date

Attending physician	Complete address	Telephone ( )	Specialty	Dates of care
Other providers treating you	Complete address	Telephone ( )	Specialty	Dates of care
Other providers treating you	Complete address	Telephone ( )	Specialty	Dates of care

(Please attach additional information if there are additional providers)

Have you applied for any of the following benefits or do you have other employment? An applicant for ICI benefits must take all necessary action to obtain and assign any other benefits available. Notify ICI if any other benefits/source of income become payable.

Yes	No		Yes	No	
☐	☐	WRS retirement benefits	☐	☐	Social Security Administration
☐	☐	WRS Disability Retirement	☐	☐	Unemployment Compensation
☐	☐	Worker's Compensation	☐	☐	Other Plan or Other Employment (specify)

3. Certification

I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I hereby authorize any and all physicians, hospitals, clinics, state and federal agencies, the Social Security Administration, etc., to release to the Income Continuation Insurance Program third-party administrator and/or the Department of Employee Trust Funds information from my health, rehabilitation, employment, Worker's Compensation, Unemployment Compensation or Social Security records. I understand 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 determining eligibility for disability benefits. A copy of this authorization shall be considered as effective and valid as the original and shall be valid for the duration of the claim but not to exceed one year from the date signed.

Signature of claimant	Date signed (MM/DD/YYYY)	Telephone ( )