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

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/CCYY)	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*. If your annual earnings exceed $64,000.00, go to Question 2.* If not, proceed to Question 3.

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

☐ I wish to cancel my ICI coverage. (Checking this box also cancels Supplemental ICI coverage, if in effect.) *Sign below.*

2. Supplemental ICI Coverage: Only available to employees whose annual earnings exceed $64,000.00 and who are currently enrolled in, or are applying for, ICI coverage. *Check One:*

☐ I elect Supplemental ICI coverage. I understand that Supplemental ICI premiums are paid by the employee with no employer contribution. I authorize payroll deductions for Supplemental ICI premiums.
(*UW Faculty/Academic Staff*: If already enrolled in ICI coverage, I understand that the elimination period previously selected will be applied to Supplemental ICI coverage.)
If you elected ICI coverage in Question 1 above, go to Question 3. If you already have ICI coverage, sign below.

☐ I do not elect Supplemental ICI coverage*. If you elected ICI coverage in Question 1, go to Question 3. If not, sign below.*

☐ I wish to cancel my Supplemental ICI coverage *only*. *Sign below.*

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

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

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 (and Supplemental ICI coverage, if applicable):
☐ 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 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 and Supplemental ICI coverage (if selected). I understand that if premiums are not deducted, I do not have ICI coverage.

Employee signature	Date	Telephone ( )

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: _____
- ☐ 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

Earnings

$ ☐ Monthly ☐ Biweekly

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

ICI monthly premium
Employer share: $ Employee share: $

Supplemental ICI monthly premium
Employee share: $

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 ( )	Effective date

Copy and distribute: ☐ ETF ☐ Employee ☐ Employer