



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 due to an employer error.

Refer to chapter 10 of the local ICI administration manual (ET-1145) for more information.

Employee Information Type or print in ink. Sign and return to <i>employer</i> . 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
<p>1. Income Continuation Insurance (ICI) coverage. Check one:</p> <p><input type="checkbox"/> I elect ICI coverage and authorize payroll deductions for premiums. If your annual earnings exceed \$64,000.00, go to question 2. If not, go to question 3.</p> <p><input type="checkbox"/> I do not elect ICI coverage. <i>Sign below.</i></p> <p><input type="checkbox"/> I wish to cancel my ICI coverage. Checking this box also cancels Supplemental ICI coverage, if in effect. Cancellation is effective the first day of the month which occurs on or after the date the application is received. <i>Sign below.</i></p> <p>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. <i>Check One:</i></p> <p><input type="checkbox"/> 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. If already enrolled in ICI coverage, I understand that the elimination period previously selected will be applied to Supplemental ICI coverage. <i>If you elected ICI coverage in Question 1 above, go to Question 3. If you already have ICI coverage, sign below.</i></p> <p><input type="checkbox"/> I do not elect Supplemental ICI coverage. <i>If you elected ICI coverage in Question 1, go to Question 3. If not, sign below.</i></p> <p><input type="checkbox"/> I wish to cancel my Supplemental ICI coverage <i>only</i>. <i>Sign below.</i> (Cancellation is effective the first day of the month which occurs on or after the date the application is received.)</p> <p>3. I elect the following calendar day elimination period for ICI coverage and Supplemental ICI coverage (if applicable):</p> <p><input type="checkbox"/> 30-day <input type="checkbox"/> 60-day <input type="checkbox"/> 90-day <input type="checkbox"/> 120-day <input type="checkbox"/> 180-day</p>					

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 ()

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 more information.

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:
<input type="checkbox"/> Began WRS participation with current employer on: _____
<input type="checkbox"/> Reinstating coverage upon return from temporary layoff or leave of absence. Date temporary layoff or leave of absence began: _____ Date employee returned: _____
<input type="checkbox"/> Changed to a longer elimination period effective on: _____ Note: Evidence of insurability is required to change to a shorter elimination period.
<input type="checkbox"/> Enrollment through employer error provision: _____ Note: More information available in chapter 10 of the local ICI administration manual (ET-1145).
<input type="checkbox"/> Other (specify): _____

Earnings	
\$	<input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly
Basis of employment	<input type="checkbox"/> Full time <input type="checkbox"/> Part-time: _____ %
ICI monthly premium	
Employer share: \$	Employee share: \$
Supplemental ICI monthly premium	
Employee share: \$	

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

Copy and distribute: ETF Employee Employer