

INCOME CONTINUATION INSURANCE APPLICATION

I. EMPLOYEE: COMPLETE PART I TYPE OR PRINT IN INK, SIGN, AND RETURN TO EMPLOYER

Name	Last	First	Middle I.	Maiden/Former	Social Security Number
	Street No.	Street Name			Birthdate (MM/DD/CCYY)
Address	City	State	Zip	Country and Mail Code (if not USA)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

Complete sections 1 – 3 (2 and 3 if applicable) and sign at section 4.

1. ICI COVERAGE

Check One

I elect ICI coverage and authorize payroll deductions for premiums. *If your annual earnings exceed \$64,000.00, go to #2. If not, proceed to #3.*

I do not elect ICI coverage. *Sign below at #4.*

I wish to cancel my ICI coverage. (Checking this box also cancels Supplemental ICI coverage, if in effect.) *Sign below at #4.*

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. 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 #1, go to #3. If you already have ICI coverage, sign below at #4.*

I do not elect Supplemental ICI coverage. *If you elected ICI coverage in #1, go to #3. If not, sign below at #4.*

I wish to cancel my Supplemental ICI coverage. *Sign below at #4.*

3. I elect the following calendar day elimination period for ICI coverage and Supplemental ICI coverage (if applicable):

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

4. 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.

Sign and Return to Employer

Signature of Employee	Daytime Telephone ()	Date (MM/DD/CCYY)
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Return to employer

II. EMPLOYER: COMPLETE PART II

Reason to submit application (Check appropriate box and indicate occurrence date)	Previous Service - Complete Information
<input type="checkbox"/> Immediately eligible on:	1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> New employee will have participated in WRS for six calendar months on:	2. Previous service check, completed <input type="checkbox"/> Yes <input type="checkbox"/> No Source of previous service <input type="checkbox"/> ONE Site <input type="checkbox"/> ETF
<input type="checkbox"/> Reinstating coverage upon return from temporary layoff or leave of absence. Date temporary layoff/LOA began: _____ Date employee returned: _____	3. Date WRS participation began with the current employer (MM/DD/CCYY)
<input type="checkbox"/> Changed to a longer elimination period effective on: (Evidence of insurability is required to change to a shorter elimination period.)	
<input type="checkbox"/> Other (specify):	

Earnings \$ <input type="checkbox"/> Monthly	Basis of Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time _____ %	ICI Monthly Premium Employee Share \$ _____ Employer Share \$ _____	Supplemental ICI Monthly Premium Employee Share \$ _____
Employer Name	Employer Identification Number (EIN) 69-036	Date Received by Employer (MM/DD/CCYY)	
Employer Agent Signature	Prepared By	Daytime Telephone ()	Effective Date (MM/DD/CCYY)

Copy and Distribute: ETF Employee Employer

