Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Local Government Employee
Wis. Stat. § 40.61

INCOME CONTINUATION INSURANCE APPLICATION

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

Member ID

Name	Last	First	Middle I.	Maiden/Former		Social Security Number
Address	Street No.	Street Name				Birthdate *(MM/DD/CCYY)*
	City	State	Zip	Country and Mail Code (if not USA)		Sex ☐ Male ☐ 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	Telephone Number ( )	Date *(MM/DD/CCYY)*

Return to employer

II. EMPLOYER: COMPLETE PART II

Reason to submit *application (Check appropriate box and indicate occurrence date)*

☐ Immediately eligible on:

☐ Reinstating coverage upon return from temporary layoff or leave of absence.

Date temporary layoff/LOA began: ______________________

Date employee returned: ______________________

☐ Changed to a longer elimination period effective on:
(Evidence of insurability is required to change to a shorter elimination period.)

☐ Other *(specify)*:

Previous Service - Complete Information

1. Did employee participate under WRS prior to being hired by you?
   ☐ Yes ☐ No
2. Previous service check, completed
   ☐ Yes ☐ No
   Source of previous service
   ☐ ONE Site ☐ ETF
3. Date WRS participation began with the current employer *(MM/DD/CCYY)*

Earnings	Basis of Employment	ICI Monthly Premium		Supplemental ICI Monthly Premium
		Employee Share	Employer Share	Employee Share
$ ☒ Monthly	☒ Full-Time ☐ Part-Time ________ %	$ 0	$ 0	$ N/A

Employer Name	Date Application Provided to Employee	Date Received by Employer *(MM/DD/CCYY)*
Marathon County Special Education	01/18/2018	01/18/2018

Employer Identification Number	Employer Agent Signature	Telephone Number	Effective Date *(MM/DD/CCYY)*
(EIN) 69-036 0943-000		(715) 261-1980	

Copy and Distribute: ☐ ETF ☐ Employee ☐ Employer