Life Insurance Application/Cancellation/Refusal

Wis. Stat. §40.70

EMPLOYEE: You have an enrollment opportunity for life insurance coverage through the Wisconsin Public Employers Group Life Insurance Program if you meet the qualifications on the reverse side of this page. Please review the reverse side and the brochure *The Wisconsin Public Employers Group Life Insurance Program* (ET-2101) very carefully for more program information.

INSTRUCTIONS FOR COMPLETING LIFE INSURANCE APPLICATION/CANCELLATION/REFUSAL FORM
NOTE : If you choose not to enroll, complete Sections 1, 2 and 4, then return this form to your employer.

Section 1 - Applicant Information

Print all requested information legibly in the space provided. Missing information may delay enrollment processing.

Section 2 - Reason for Application

Indicate the reason for completing the form:

Enrollment: Select this option to enroll if you are newly hired or newly eligible for life insurance. Check the box(es) next to all coverage for which you wish to enroll in Section 3, Coverage Selection.

Decline Coverage: Select this option if you choose not to enroll.

Cancellation: Check the box(es) next to all coverage you wish to cancel in Section 3, Coverage Selection. You may cancel all or part of your life insurance coverage. If Basic coverage is canceled, all other life insurance coverage is automatically canceled. Coverage will end at the end of the month in which your employer receives the cancellation application. If you wish to re-enroll at a later date, you must apply through evidence of insurability, unless you experience a qualifying family status change event.

Note: When you retire and reach age 65, your Basic life insurance will continue at no cost to you. If you are actively working, your Basic life insurance will continue at no cost to you beginning at age 70. Please consult your employer or ETF for more information about this benefit.

Transfer: (Employees of State agencies as designated in Wis. Stat. 40.02 (54) and the UW only) Indicate the agency you are transferring from and the agency you are transferring to, as well as the effective date of transfer. Only coverage that is in force at the time of your transfer will be maintained.

Reinstate Coverage: Use this option to reinstate coverage that lapsed while on an unpaid leave of absence (LOA). Be sure to provide your LOA start and end dates. Only coverage that was in force at the time you began your unpaid leave will be reinstated.

Enrollment or Coverage Increase Due to Family Status Change: Select this option if you are enrolling in Basic coverage or increasing coverage for yourself or if you are adding Spouse & Dependent coverage due to a qualifying family status change. Enrollment must be within 30 days of the qualifying event, and coverage can be increased by one level (1x earnings) of employee coverage or one or two units of Spouse & Dependent coverage. Check the box next to the coverage level that you wish to add in Section 3, Coverage Selection.

Section 3 - Coverage Selection

Select the coverage options that you wish to enroll in or cancel.

Section 4 - Signature

Sign and date the application.
Submit this form to your employer. Your employer will complete Section 5 and provide you with a copy.

EMPLOYER: Please complete the processing of this form by doing the following:

Section 5 - Employer Completes

Please collect this form from all employees when they become eligible for enrollment, **even if they choose not to enroll.**

It is important to provide all the information requested in Section 5. The “Date received from employee” must be completed. Omissions may delay enrollment.

NOTE: If the form is late due to employer error, a letter of explanation **must be** attached to the application or the application will be returned to you.

Employer must forward a copy of the completed form to ETF at P.O. Box 7931, Madison, WI 53707-7931. Keep a copy for yourself; give the employee a copy.

The employee’s coverage amount will be based on the estimated earnings that the employer provides on the application. The employer should provide estimated earnings for a full calendar year period.

Wisconsin Public Employers Group Life Insurance Program

You have an enrollment opportunity for life insurance coverage through the Wisconsin Public Employers Group Life Insurance Program if you:

- Are under age 70;
- Are enrolled in the WRS with your current employer; and
- Apply within 30 days of eligibility.

You have an opportunity to enroll in Basic coverage or to increase employee coverage by one level (1x earnings) or add one or two units of Spouse & Dependent coverage if you apply within 30 days of one of the following family status changes:

- Marriage;
- Birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

If you do not enroll for all available coverage when you are eligible, you may apply for future coverage through *Evidence of Insurability* (ET -2305).

Plan Summary

The Wisconsin Public Employers (WPE) Group Life Insurance program offers employee coverage of up to five times your annual earnings. All five levels of insurance are available to state employees. The amount of coverage available to local government employees depends on which plans are offered by your employer. The following is a summary of the life insurance coverage that is available.

Coverage Options

The **Basic Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000.

The **Supplemental Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000.

The **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your earnings for the previous year, rounded up to the next $1,000. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of Additional coverage.

The **Spouse & Dependent Plan** provides coverage for your spouse and all dependent(s). If you elect one unit of coverage, your spouse will have $10,000 in coverage and each dependent (regardless of the number) will have $5,000 in coverage. If you elect two units, your spouse will have $20,000 in coverage and each dependent will have $10,000 in coverage.

Amount of Coverage

The following is an example of how the amount of employee coverage is determined for an employee who chooses Basic, Supplemental and 3 Units of Additional coverage. The employee's previous year earnings are $53,200. The earnings rounded up to the next thousand equals $54,000 of coverage. The employee has coverage as follows:

Basic: (1x earnings) = $54,000

Supplemental: (1x earnings) = $54,000

Additional (3 units): (3x earnings) = $162,000

Total Amount of Insurance Coverage: (5x earnings) = $270,000

Coverage for Active Employees Age 70 and Over

If you are actively employed when you turn age 70, your Basic coverage will reduce to the final post-retirement coverage amount and continue for life with no premiums due. Your Supplemental and Spouse & Dependent coverage will cease on your 70th birthday. Your Additional coverage will continue until you cancel coverage or terminate employment.

Effective Date of Coverage

If you file an application within 30 days after becoming eligible, the effective date will be the first day of the month following 30 days from the date of hire or the first day of the month following 30 days from the date of the qualifying family status change event. For claims purposes, an employee's election date will be the point of reference for providing coverage and paying claims. Election date is the "Date received by employer" (or the date received by ETF if eft incomplete) but not earlier than the date of hire or the date of the qualifying family status change event.

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1. Applicant Information

Applicant— name (last, first, middle, previous)			ETF Member ID
Social Security number	Date of birth	Telephone number	Gender ☐ Male ☐ Female

2. Reason for Application - (check all that apply)

☐ **Enrollment:** I want to enroll for the life insurance coverage indicated in section 3 and I hereby authorize deductions from my earnings for premium.

☐ **Decline Coverage:** I do not wish to enroll at this time. I understand that if I wish to enroll at a later date I must apply and submit evidence of insurability.

☐ **Cancellation:** I wish to voluntarily cancel the life insurance coverage indicated in section 3. I understand that if I wish to re-enroll at a later date, I must apply and submit evidence of insurability, or enroll due to a qualifying family status change event. Coverage will end at the end of the month in which your employer receives the cancellation application.
Reason_____ Date_____

☐ **Transfer:** (State agency and UW employees only) From (agency)_____ To (agency)_____
Date of transfer_____
I understand that I am entitled to have only the coverage that is in force at the time of the transfer.

☐ **Reinstate Coverage:** I am reapplying for the coverage that lapsed while on an unpaid Leave of Absence (LOA). I understand I am entitled to have only the coverage that was in force at the time my unpaid leave began.
LOA Began_____ (mm/dd/ccyy) LOA Ended_____ (mm/dd/ccyy)

☐ **Enrollment or Coverage Increase Due to Family Status Change:** I want to enroll for the life insurance coverage indicated in section 3 and I hereby authorize deductions from my earnings for premium. Coverage increase is limited to one level of employee coverage (1x earnings). You may elect 1 or 2 units of Spouse & Dependent coverage.

Qualifying event_____

Date of marriage, birth, adoption, placement for adoption, or award of legal guardianship of a dependent child.

_____

3. Coverage Selection

☐ **Basic Coverage (1x earnings)** ☐ **Supplemental Coverage (1x earnings)**

Spouse & Dependent Coverage (check one)
☐ 1 Unit (Spouse = $10,000; Dependent = $5,000)
☐ 2 Units (Spouse = $20,000; Dependent = $10,000)

Additional Coverage (check one)
☐ 1 Unit (1x earnings)
☐ 2 Units (2x earnings)
☐ 3 Units (3x earnings)

4. Signature - (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 information is true and correct.

Applicant signature	Date signed (mm/dd/ccyy)
X	

5. Employer Completes

ETF Employer number	Name of employer	Employer billing unit number
69-036-		

Employer agent signature	Prepared by	Telephone number
X		
Date WRS employment began with current employer (mm/dd/ccyy)	Date provided to employee (mm/dd/ccyy)	Date received from employee (mm/dd/ccyy)
Coverage effective date (mm/dd/ccyy)	Full calendar year earnings (12 month earnings)	Earnings are ☐ Estimate ☐ Actual