

**INCOME CONTINUATION INSURANCE APPLICATION**

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

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

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

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 #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. (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 #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 only. Sign below at #4.

3. Answer only those questions applicable to your employment status (once completed, sign below at #4.):

**STATE EMPLOYEES AND UW FACULTY/ACADEMIC STAFF:**

I was most recently employed by the following State agency: \_\_\_\_\_ From (MM/DD/CCYY) \_\_\_\_\_ To (MM/DD/CCYY) \_\_\_\_\_

**UW FACULTY/ACADEMIC STAFF ONLY:**

I elect the following 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 (upon completion of 6 mos. WRS service) \_\_\_\_\_  When State contributes toward premium (defer coverage for 12 months) \_\_\_\_\_

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) \_\_\_\_\_

**II. EMPLOYER: COMPLETE PART II**

<b>Reason to submit application (Check appropriate box and indicate occurrence date)</b>	<b>Previous Service - Complete Information</b>
<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
<input type="checkbox"/> Reinstating coverage upon return from temporary layoff or leave of absence. Date temp layoff/LOA began: _____ Date employee returned: _____	Source of previous service <input type="checkbox"/> Extranet <input type="checkbox"/> ETF
<input type="checkbox"/> Transferred from another State agency on:	3. Date WRS participation began with the current employer (MM/DD/CCYY)
<input type="checkbox"/> (UW Faculty/Academic Staff only) Changed to a longer elimination period effective on: _____ (Evidence of Insurability is required to change to a shorter elimination period.)	
<input type="checkbox"/> Eligible through deferred coverage (State employees and UW Faculty/Academic Staff) on:	
<input type="checkbox"/> Other (specify): _____	

Earnings	Basis of Employment	ICI Monthly Premium		Supplemental ICI Monthly Premium
\$ <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly	<input type="checkbox"/> Full-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Project <input type="checkbox"/> Part-Time _____ % <input type="checkbox"/> Academic Year <input type="checkbox"/> LTE	Employee Share	Employer Share	Employee Share
		\$	\$	\$

**SICK LEAVE INFORMATION FOR DEFERRED COVERAGE OR REINSTATED OR REHIRED EMPLOYEES**

Total accumulation of sick leave credits for the preceding 2 calendar years:

Year	Beginning Balance	Sick Leave Earned	Sick Leave Used	Ending Balance

Employer Name	Employer Identification Number (EIN) 69-036	Date Received by Employer (MM/DD/CCYY)
Employer Agent Signature	Prepared By	Effective Date (MM/DD/CCYY)
	Daytime Telephone ( )	