Life Insurance Application/Cancellation/Refusal

Wis. Stat. §40.70

EMPLOYEE: You have an open 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 following 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.

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 or increasing coverage for yourself 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) only. Check the box next to the coverage level that you wish to add in Section 3, Coverage Selection.

Spouse & Dependent Coverage Enrollment: Use this option only if you are currently insured and wish to add Spouse & Dependent Coverage. Enrollment must be within 30 days of the date that you **first** have a spouse/domestic partner or dependent child to insure. The addition of a spouse/domestic partner or dependent is not a qualifying event if you previously had a spouse/domestic partner or dependent(s) who were eligible for coverage.

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 open enrollment, **even if they choose not to enroll.**

It is important to provide **all** the information requested in Section 5. Omissions may delay enrollment processing.

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. Keep a copy for yourself; give the employee a copy.

Review your Group Life Insurance Employer Administration Manual (ET-1117) for further program information and instructions.

Wisconsin Public Employers Group Life Insurance Program

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

- Are under age 70;
- Have worked six or more months in service covered by the WRS;
- Have not withdrawn WRS contributions following your most recent six months of employment; and
- Apply within 30 days of your first eligibility, (or for Spouse & Dependent coverage only, when you have a spouse/domestic partner or dependent to insure for the **first** time.)

You have an opportunity to enroll or to increase coverage by one level (1x earnings) if you apply within 30 days of one of the following family status changes:

- Marriage;
- Establishment of a Domestic Partnership in accordance with Wis. Stat. §40.02 (21d);
- 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 first 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. Your employer is required to contribute to the cost of this insurance.

The **Supplemental Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000. The state contributes to the cost of this coverage for state employees. Local government employers are not required to contribute.

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. Employer contributions are not required.

The **Spouse & Dependent Plan** provides coverage for your spouse/domestic partner and all dependent(s). If you elect one unit of coverage, your spouse/domestic partner 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/domestic partner 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 $33,200. The earnings rounded up to the next thousand equals $34,000 of coverage. The employee has coverage as follows:

Basic: (1x earnings) = $34,000
Supplemental: (1x earnings) = $34,000
Additional (3 units): (3x earnings) = $102,000
Total Amount of Insurance Coverage: (5x earnings) = $170,000

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, coverage becomes effective on the first of the calendar month which begins on or after the date the application is received by your employer. Coverage cannot become effective before you are eligible and cannot be in effect for part of a month.

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1. APPLICANT INFORMATION

Applicant name (last, first, middle, previous)			
Social Security number	Date of birth	Daytime 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.

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**: Coverage increase is limited to one level of employee coverage (1x earnings).

Qualifying event _____ Date of marriage, affidavit of Domestic Partnership (ET-2371) received by ETF, birth, adoption, placement for adoption, or award of legal guardianship of a dependent child _____

☐ **SPOUSE & DEPENDENT COVERAGE ENROLLMENT DUE TO QUALIFYING EVENT**: Enrollment must occur within 30 days of the date you **first** have a spouse/domestic partner or dependent child to insure.

Qualifying event _____ Date of marriage, affidavit of Domestic Partnership (ET-2371) received by ETF, birth or adoption of a child _____

3. COVERAGE SELECTION

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

Spouse & Dependent Coverage (check one)

☐ 1 Unit (Spouse/Domestic Partner = $10,000; Dependent = $5,000)

☐ 2 Units (Spouse/Domestic Partner = $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)
Date new employee will have participated in WRS for 6 months (mm/dd/ccyy)	Calendar year earnings	Year	Earnings are ☐ Estimate ☐ Actual
Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No Source of previous service check: ☐ Online Network for Employers (ONE) ☐ ETF		Previous service check completed? ☐ Yes ☐ No Has employee withdrawn their WRS contribution? ☐ Yes ☐ No	

ET-2304 (Rev 3/2012) **COPY AND DISTRIBUTE:** ☐ **ETF** ☐ **Employer** ☐ **Employee**

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