

State Agencies

Employee and Employer Completion of Income Continuation Insurance Application (ET-2307, rev. 12/2004)

Employee Completion of ICI Application

The employee **must** complete the following items on the *Income Continuation Insurance Application* (ET-2307) and return the application to the employer no later than 30 days following their initial eligibility date.

Employee Section I.

- A. Complete legal name.
- B. Entire permanent address.
- C. Social Security number.
- D. Birthdate (the employee must be under age 70).
- E. Gender.

Section 1 – ICI Coverage

- F. Check the box indicating the election of ICI Coverage, the choice not to elect coverage, or the desire to cancel coverage.

Employees electing ICI coverage whose annual earnings exceed \$64,000 should proceed to section 2. Employees with earnings of \$64,000 or less should proceed to section 3.

Employees not electing ICI coverage or canceling coverage should proceed to section 4.
(Note: Canceling ICI coverage automatically cancels any supplemental coverage.)

Section 2 – Supplemental ICI Coverage

- G. Available to employees whose annual earnings exceed \$64,000 and who are enrolled in, or initially applying for, ICI coverage.

Check the appropriate box indicating the election of, the choice not to elect, or the desire to cancel, supplemental ICI coverage. (Note: Checking the box indicating a cancellation of supplemental coverage is appropriate for those employees wishing to cancel supplemental ICI coverage but maintain ICI coverage for their earnings up to \$64,000.)

Employees electing supplemental ICI coverage as part of their initial enrollment in ICI coverage should proceed to section 3. Employees electing supplemental ICI coverage who already have ICI coverage should proceed to section 4.

Employees not electing supplemental ICI coverage or canceling coverage should proceed to section 4.

Section 3 – Questions applicable to employment status

H. *State Employees and UW Faculty/Academic Staff.*

Indicate the most recent previous State agency at which the applicant was employed, if any, and the dates of employment.

I. *UW Faculty/Academic Staff only.*

Select an elimination period and indicated coverage should become effective.

Note to UW Faculty/Academic Staff—Select an elimination period if:

- applying for ICI coverage;
- applying for ICI coverage and supplemental coverage;
- applying for a longer elimination period than last selected. (Evidence of Insurability is required to change to a shorter elimination period.)

UW Faculty/Academic Staff members currently enrolled in ICI who are electing supplemental ICI coverage should not complete this section unless they wish to lengthen their elimination period; in these cases the employer must check the appropriate box in the “Employer Section” or the application will be returned.

Section 4 – Employee Signature

J. Employee signature. (If missing, the application is invalid and will be returned for signature.)

K. Employee’s daytime telephone number.

L. Date of signature.

Employee returns application to employer.

Employer Completion of ICI Application

Employer Section II

The employer **must** complete the following items on the *Income Continuation Application* and forward the application to ETF.

A. Indicate the reason for submitting the application by checking the appropriate box and indicating the occurrence date.

Immediately Eligible On. Check this box for employees who previously completed six months of service under the WRS. Indicate the occurrence date.

New employee will have participated in WRS for six calendar months on. Check this box for new employees and rehired employees who have not previously completed six calendar months of service under the WRS and indicate the occurrence date.

- Reinstating coverage upon return from layoff or leave of absence.**
Date temporary layoff/LOA began: _____
Date employee returned _____. Check this box if an employee who previously had ICI coverage takes a leave of absence, allows coverage to lapse and then returns to eligible employment. Insert the date the leave began and the date the employee returned from leave. Indicate the occurrence date.
- Transferred from another State agency on.** Check this box for employees transferring from another State agency and indicate the transfer date.
- (UW Faculty/Academic Staff only) Changed to a longer elimination period effective on:** Check this box if the employee wants to elect a longer elimination period. An employee may change to a longer elimination period at any time. However, if an employee wants to change to a shorter elimination period, the employee must apply through evidence of insurability.
- Eligible through deferred coverage (State employees and UW Faculty/Academic Staff) on.** Check this box for employees eligible through deferred coverage and indicate the coverage begin date.
- Other.** Check this box for a situation that does not fit one of the other categories listed above. *Check this box and indicate the coverage begin date for an employee applying for supplemental ICI coverage during the annual deferred enrollment period.* Or for example, if an employee is reinstated through a grievance/settlement, indicate the date the employee returns to work.

B. Previous Service

Indicate if the employee participated under WRS prior to being hired by you, whether you have completed a previous service check and the source of the check, and the date WRS participation began with you.

C. Earnings

- D. Use the employee's WRS earnings as reported in the preceding calendar year or, if applicable, the employee's projected calendar year earnings and indicate whether the earnings are monthly or biweekly

E. Basis of Employment

Check whether the employee's basis of employment is full-time, part-time, seasonal, project, academic year, LTE, or part-time. If part-time, indicate the percentage of full-time employment.

F. ICI Monthly Premium

Indicate the appropriate employee and employer premium share.

G. Supplemental ICI Monthly Premium

Indicate the premium; refer to the Supplemental premium rate sheet. (The employee pays the entire premium for supplemental ICI coverage.)

H. Sick Leave Information for Deferred Coverage or Reinstated or Rehired Employees

Indicate the total accumulation of sick leave credits for the previous 2 calendar years.

I. Employer name -- Use the same name used for Social Security reporting.

J. Employer Number 69-036

The Employer Identification Number (EIN) is a 12-digit number beginning with 69-036. Indicate the last seven digits of this number (XXXX-XXX).

K. Date Received by Employer

The date the employer received the employee's completed application. This date determines when the insurance becomes effective. If this date is missing the coverage effective date will be based on the date ETF receives the application and could cause delay or denial of coverage.

L. Employer Agent Signature

The WRS agent or designated representative must certify that the information on the application is true and correct.

M. Prepared By – Indicate the name of the person preparing the form.

N. Daytime Telephone Number. The telephone number of the employer contact person/preparer.

O. Effective Date (MM/DD/CCYY)

Indicate the coverage effective date--the first of the month on or following receipt of application by the employer. For example: For an application received on the 1st of the month, coverage begins on the 1st. For applications received on the 2nd through the 31st of the month, coverage begins the first of the following month. For applications received on or prior to the employee's eligibility date, coverage becomes effective on the eligibility date.