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

EMPLOYER RESOLUTION TO PAY ENTIRE PREMIUM FOR:

Check box(es):

- ☐ Basic Group Life Insurance
- ☐ Supplemental Group Life Insurance
- ☐ Additional Group Life Insurance
- ☐ Spouse and Dependent Group Life Insurance

I hereby certify that pursuant to Wis. Stats. 40.05 (6)(e), a resolution to pay the entire group life insurance premium for the plan(s) indicated above was duly made by the

____
(Governing Body)

of the ____
(Employer Name)

Employer Identification Number (EIN): 69-036-________________________ on

______________________.
(Date Action Taken)

I understand that Wis. Stats. 943.395 provides criminal penalties for knowingly making false or fraudulent statements on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct.

Date (MM/DD/CCYY)	WRS Agent Signature	Title

(For ETF use only)

Effective Date of Coverage entered by ETF: