A RESOLUTION FOR INCLUSION UNDER THE WISCONSIN PUBLIC EMPLOYERS' GROUP HEALTH INSURANCE PROGRAM

RESOLVED, by the ______________________ of the ______________________________ (Governing Body) (Employer Legal Name) that pursuant to the provisions of Wis. Stat. § 40.51 (7) hereby determines to offer the Group Health Insurance Program to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the program as set forth in the contract between the Group Insurance Board and the participating health insurance providers.

All participants in the WPE Group Health Insurance Program will need to be enrolled in a program option. An employer may elect participation in one, two, three or all four program options listed below, with each program option to be offered to different employee classifications (pursuant to collective bargaining). Individual employees cannot choose between program options.

We choose to participate in the:  (check applicable options)

☐ Traditional HMO-Standard PPO, P02
☐ Deductible HMO-Standard PPO, P04
☐ Coinsurance HMO-Standard PPO, P06
☐ High Deductible Health Plan HMO-Standard HDHP PPO, P07

The underwriting and enrollment process takes 120 days. Groups are eligible to enroll effective January 1, April 1, July 1, or October 1. **RESOLUTION EFFECTIVE DATE:** (select one date): ____________.

The proper officers are herewith authorized and directed to take all actions and make salary deductions for premiums and submit payments required by the State of Wisconsin Group Insurance Board to provide such Group Health Insurance.

**CERTIFICATION**

I hereby certify that the foregoing resolution is a true, correct and complete copy of the resolution duly and regularly passed by the above governing body on the ___ day of _______, year _________ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this ___ day of _____________, year _________.

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

ETF EMPLOYER IDENTIFICATION NUMBER

EMPLOYER REPRESENTATIVE TITLE

MAILING ADDRESS

FEDERAL TAX IDENTIFICATION NUMBER (FEIN/TIN)

COUNTY WHERE EMPLOYER IS LOCATED

NUMBER OF ELIGIBLE EMPLOYEES EMAIL ADDRESS