# Resolution for Inclusion Under the Income Continuation Insurance Plan

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

RESOLVED, by the _____ of the
(Governing Body)

_____ of _____
(Employer Legal Name)

that pursuant to the provisions of Section 40.61 of the Wisconsin Statutes,

_____ hereby determines to offer the Income Continuation Insurance Plan
(Governing Body)

to eligible personnel through the program of the State of Wisconsin Group Insurance Board, and agrees to abide by the terms of the plan as set forth in the contract between the Group Insurance Board and the Administrator.

The resolution shall be effective on the later of the 1st of the month on or after 90 days following its receipt at the Department of Employee Trust Funds, or

_____ ; and
(specify a later effective date, 1st of month only)

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 Income Continuation Insurance.

Employers are required to pay a *minimum* contribution, which is equal to the gross premium for the 180-day elimination period. Employers may choose to contribute more to employees' premiums to an amount equal to the gross premium for a *shorter* elimination period. As elimination periods become shorter, the premium cost increases.

An employee can choose a shorter elimination period than that offered by their employer, and pay the difference in cost between their choice and the elimination period the employer for which the employer has elected to pay the gross premium.

For example, if an employer elects to pay for the full 90-day elimination period, = their employees will not have out-of-pocket premiums unless the employee elects the 60-day or 30-day elimination period. If the employee elected a shorter elimination period, the employee will pay the premium difference between that and the 90-day elimination period.

**Elect one elimination period that your employer will pay the gross ICI premium for:**

- ☐ 30-day elimination period ☐ 60-day elimination period
- ☐ 90-day elimination period ☐ 120-day elimination period
- ☐ 180-day elimination period *(required minimum contribution)*

***Complete the Certification on the next page.***

**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 _____, _____ and that said resolution has not been repealed or amended, and is now in full force and effect.

Dated this _____ day of _____, _____.

Federal tax identification number (FEIN/TIN)

Authorized employer representative signature

**69-036-**

ETF employer identification number

Authorized employer representative printed name

Number of eligible employees _____

Authorized representative title

Employer county

Employer benefit contact email address

Mailing address

Submit completed form to ETF at ETFSMBESSNewEmployer@etf.wi.gov or fax to 608-267-4549.

*For ETF use only* - EFFECTIVE DATE OF COVERAGE ENTERED BY ETF: