

**EVIDENCE OF INSURABILITY APPLICATION**  
(Income Continuation Insurance)  
Wis. Stat. § 40.61

To keep your application confidential, enclose it in a sealed envelope and submit directly to the Department of Employee Trust Funds.

Clearly print or type your Name and address below:

First MI Last

Social Security Number		
Birthdate (MM/DD/CCYY)		
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height ft. in.	Weight lbs.

- Have you ever applied through ICI Evidence of Insurability before?  Yes  No
- Are you applying to shorten your waiting period?  Yes  No
- In addition to ICI, are you applying for supplemental coverage?  Yes  No  
(annual earnings must exceed \$64,000 to be eligible for supplemental)

Current Employer or Department	
Employer Number 69-036	
Occupation	Date Eligible for WRS (MM/DD/CCYY)

<b>UW FACULTY AND ACADEMIC STAFF</b>	<b>LOCAL GOVERNMENT EMPLOYEES ONLY</b>
I elect the following waiting period (calendar days): <input type="checkbox"/> 30 day <input type="checkbox"/> 125 day <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day	I elect the following waiting period (calendar days): <input type="checkbox"/> 30 day <input type="checkbox"/> 90 day <input type="checkbox"/> 180 day <input type="checkbox"/> 60 day <input type="checkbox"/> 120 day

**ANSWER EACH OF THE FOLLOWING QUESTIONS CAREFULLY AND COMPLETELY** YES NO

- Are you presently in good health and free from physical impairment and pregnancy? If no, explain.  YES  NO
- Has any life, health, or accident and sickness insurance application including Income Continuation Insurance been cancelled, rejected, or assigned to a special rate category because of your medical condition? If yes, explain.  YES  NO
- Have you, within the last 5 years, made claim for or received disability or retirement payments because of an illness or injury? If yes, give date, amount, company, type of illness or injury, type of insurance, and reason.  YES  NO
- During the last 5 years have you been hospitalized, had surgery, or been advised to have surgery? If yes, give date, hospital, doctor and diagnosis.  YES  NO
- Have you, within the last 5 years, missed work for more than two weeks because of an illness or injury? If yes, list dates of time off and type of illness or injury.  YES  NO
- Have you ever been diagnosed or received treatment by a health care provider or had reason to suspect you have had any of the following:
 

<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> Arthritis, Bursitis or Gout	<input type="checkbox"/> Conditions of the Brain or Nervous System
<input type="checkbox"/> Chest Pain, Angina, or Shortness of Breath	<input type="checkbox"/> Disorder of Back, Neck or Spine	<input type="checkbox"/> Conditions of the Eyes, Ears, Nose or Throat
<input type="checkbox"/> Disorder of Heart Muscles, its Nerves or Vessels	<input type="checkbox"/> Disorder of Muscles, Bones or Joints	<input type="checkbox"/> Conditions of the Skin or Lymph Nodes
<input type="checkbox"/> Irregular Heart Beat, Murmur or Rheumatic Fever	<input type="checkbox"/> Temporomandibular Joint Syndrome (TMJ)	<input type="checkbox"/> Conditions of the Prostate, Ovaries or Uterus
<input type="checkbox"/> Abnormal Blood Pressure	<input type="checkbox"/> Recurrent Abdominal Pain or Hernia	<input type="checkbox"/> Conditions of the Stomach, Intestines, Gallbladder or Liver
<input type="checkbox"/> Disorder of Veins or Arteries	<input type="checkbox"/> Stroke, Epilepsy or Seizure Disorder	<input type="checkbox"/> Conditions of the Thyroid or any Gland
<input type="checkbox"/> Diabetes, High or Low Blood Sugar	<input type="checkbox"/> Migraine or Persistent Headaches	<input type="checkbox"/> Treatment to limit use of Alcohol, Other Chemicals or Drugs
<input type="checkbox"/> Disorder of Kidneys or Bladder	<input type="checkbox"/> Mental or Nervous Disorder	<input type="checkbox"/> AIDS or any Disorder of Immune System*
<input type="checkbox"/> Venereal Disease, Syphilis, Gonorrhea, Genital Warts or Genital Herpes	<input type="checkbox"/> Dizziness or Paralysis	<input type="checkbox"/> Human Immunodeficiency Virus (HIV)*
<input type="checkbox"/> Protein, Blood or Sugar in Urine	<input type="checkbox"/> Asthma, Emphysema, Breathing or Lung Disorder	<input type="checkbox"/> AIDS Related Complex (ARC)*
<input type="checkbox"/> Night Sweats, Persistent Swollen Glands, or Diarrhea	<input type="checkbox"/> Indigestion, Ulcers or Colitis	*You are not required to submit, nor are we seeking a result of an HIV Antibody Test.
	<input type="checkbox"/> Cancer of any Type, Past or Present	
	<input type="checkbox"/> Tumor or Cysts	

- If any of the above are checked, give date, nature and period of disability, doctor's name and address and result. \_\_\_\_\_
- Physician who is most familiar with your medical history. Please include physician's full name, address, city, state, zip code.  
Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Date last visited: \_\_\_\_\_ Reason for visit: \_\_\_\_\_  
Other Physician(s) consulted within the last 5 years: (Add additional names and addresses on a separate sheet of paper, if necessary.)  
Name: \_\_\_\_\_ Address: \_\_\_\_\_

Upon approval of this application I hereby authorize payroll deductions from my earnings. I hereby authorize any and all physicians, hospitals, clinics, etc. to release to the Wisconsin Department of Employee Trust Funds or the ICI Program Administrator information from my health record. I understand that the specific type of information to be released includes any and all medical and/or treatment records, and may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testings and results, and/or treatment records. This release is being made for the purpose of applying for insurance. A copy of this authorization shall be considered as effective and valid as the original and is effective for 90 days from the date signed below.

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 above information is true, correct and complete.

Date (MM/DD/CCYY)	Signature	Telephone No.: Work: ( ) Home: ( )
<input type="checkbox"/> _____ did not respond to several requests for additional medical information <input type="checkbox"/> The medical information received from _____ indicates _____ Reapply: _____ Application: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED Date: _____ By: _____		For ETF only. Effective date of Coverage (MM/DD/CCYY)

## EVIDENCE OF INSURABILITY INSTRUCTIONS

Income Continuation Insurance  
Wis. Stat. § 40.61

The Evidence of Insurability application allows you to apply to enroll in the Income Continuation Insurance program if you did not enroll when originally eligible (open enrollment period) or if coverage was cancelled. This includes unclassified teachers at the University of Wisconsin and local employees who wish to change to a shorter waiting period. You are responsible for the cost of any medical examination(s).

In order to be approved, you must demonstrate good health satisfactory to the plan administrator and must be seen by a physician for a physical examination within 12 months of the date the application is submitted. You must be under 70 years of age to apply for Income Continuation Insurance.

To apply for supplemental ICI coverage in addition to ICI coverage, your annual earnings must exceed \$64,000. You cannot use this form to apply for supplemental ICI coverage only. Supplemental ICI premiums are paid by the employee with no employer contribution.

The insurance coverage effective date shall be the first day of the calendar month which begins on or after the date the application is approved.

Complete the form in its entirety to ensure timely processing of your application. **Answer all questions completely.** If a question is not answered, or the question is not answered completely, the form will be returned to you.

Enter the date you completed the application. Your completed application must be received by the Department of Employee Trust Funds no later than one month from this date in order to ensure current medical information.

**Your signature is required.**

Mail the completed application directly to:

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

Your copy of the application will be mailed to you in approximately 60 to 90 days after insurability has been determined. The Department of Employee Trust Funds will notify you and your employer of denial or approval and the effective date of coverage, if applicable.

Personally identifiable information, such as your Social Security number, date of birth, etc., will not be used for any purpose other than for the administration of the benefit programs administered by the Department of Employee Trust Funds.