

**DEPARTMENT OF EMPLOYEE TRUST FUNDS**

P.O. Box 7931  
Madison, WI 53707-7931

**CONTINUATION APPLICATION**

**Group Life Insurance**  
Section 40.72 (4), Wis. Stat.

**EMPLOYER:** Complete the information in Parts A, B, and C below. Keep a copy for your records, then give the entire form, including the cover sheet, to the employee.

<b>A. EMPLOYEE NAME</b> (Last, first middle, maiden/former)		Social Security Number	
Date Employment Began With This Employer (MM/DD/CCYY)	Date Employment Terminated With This Employer (MM/DD/CCYY)	Birthdate (MM/DD/CCYY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
Last Coverage Month For Which Premiums Were Paid: <small>(Premiums are for the month of termination and the following month. Refund any premiums paid for later months.)</small>		Previous Calendar Year WRS Earnings \$ _____ Year	

**B. CURRENT COVERAGE AMOUNT AND ANNUAL PREMIUM**

PLAN	MONTHLY PREMIUM	CURRENT ANNUAL PREMIUM
BASIC	\$ _____	X 12 = \$ _____
SUPPLEMENTAL	\$ _____	X 12 = \$ _____
ADDITIONAL	\$ _____	X 12 = \$ _____
<b>TOTAL COVERAGE</b>	\$ _____	<b>TOTAL PREMIUM</b> \$ _____

**C.** 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 information is true and correct.

Date Prepared (MM/DD/CCYY)	Employer Agent Signature		
Prepared By	Telephone Number ( _____ )	ETF Employer Number 69-036-	
Employer Name/ WI Department of _____			Local Employer Billing Unit No.

**EMPLOYEE:** Complete the information below, sign and date the form, and return it to the Department of Employee Trust Funds within 31 days after the date your insurance coverage ends. Make a photocopy for your records.

- Check any of the statement(s) that apply to you:
  - I was covered under the Wisconsin Retirement System (WRS) before 1990.
  - I was covered under the group life insurance plan for a part of at least 5 calendar years.

If you checked either statement, go to question 2. If neither statement applied to you, you do not qualify to continue the insurance.
- Check any of the statement(s) that apply to you:
  - I meet all the requirements for receiving an immediate WRS annuity except filing the application.
  - The sum of my creditable years of WRS service before January 1, 1990 plus the number of years I have participated in the life insurance plan beginning on January 1, 1990 equals 20 years.
  - The number of years I have been employed with my last employer is 20 years or more.

If you did not check any of the above, you do not qualify to continue life insurance. If you checked at least one of the above, you qualify to continue the life insurance. If you qualify, please answer questions 3 and 4 below.
- I want to continue all of my current coverage listed above in Section B.      Yes    No\*
 

\*If you answered "No", please complete and attach an *Application Cancellation/Refusal* form (ET-2304) indicating which coverage you wish to cancel.
- I prefer to be billed:    Annually    Semiannually
 

*Premiums are due until age 65. They are based on the current rates in effect for your age group.*
- Certification/signature: I have read the entire "Continuation Application" and I understand it. I wish to continue my group life insurance coverage. I understand that if I fail to pay premiums in the future, my insurance coverage will lapse on the last day for which premiums were paid and will not be reinstated unless premiums are paid within 30 days. 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 information is true and correct.

Date (MM/DD/CCYY)	Employee Signature	Telephone Number (8 a.m. – 4 p.m.)
Address	Street	City State Zip