

**SUPPLEMENTAL TERM LIFE INSURANCE
APPLICATION/CHANGE FORM INSTRUCTIONS**

EMPLOYEE INFORMATION:

You have an open enrollment opportunity for life insurance coverage through University of Wisconsin Hospital and Clinics Supplemental Term Life Insurance Plan if you meet all of the following criteria:

- Are working for the University of Wisconsin Hospital and Clinics,
- Are eligible for state contributions to the State of Wisconsin Group Health Insurance Program,
- Are not collecting a Wisconsin State Retirement benefit, and
- Apply within 30 days of your first eligibility. For spouse/domestic partner coverage you must apply within 30 days of the date that you have a spouse/domestic partner to insure. For child coverage you must apply within 30 days of the date of birth or date of adoption of your first child.

If you do not enroll for all available coverage when you are first eligible, you may only apply for future coverage through Evidence of Insurability.

Please review the plan summary on the reverse side of this application and the brochure for the Supplemental Term Life Insurance carefully for program information. A certificate of insurance will be sent to you after enrollment.

INSTRUCTIONS:

1. Complete the top part of the application, Section I: Employee Information.
2. Indicate the reason for completing the form in Section II: Enrollment or Change Section.
 - A. Check Box A to indicate that you (the employee) are enrolling for coverage. This includes coverage for yourself, your spouse, domestic partner, your child or your domestic partner's child. Check all that apply under Section II Part A. Then be sure to complete Section III Part A.
 - B. Check Box B to indicate that you are reducing life insurance coverage on yourself, your spouse/domestic partner, or child. Indicate the amount of reduced insurance in Section III: Employee Coverage, Box B. NOTE: Coverage amounts for spouse/domestic partner or child cannot exceed the coverage you have on yourself.
 - C. Check Box C to indicate that you are canceling life insurance coverage on yourself, your spouse/domestic partner, or child. Check the plans you are canceling in Section III: Employee Coverage, Box C. NOTE: Once employee coverage is canceled, all other life insurance coverage is automatically canceled.
 - D. Check Box D to report a legal name change for you (the employee).
3. Sign and date the form. Retain a copy for your records. Then submit the remaining two plies to your Human Resources office.

EMPLOYER:

1. Review employee information for completeness and accuracy.
2. Complete the Office Use Only section.
3. Forward the top ply to the address listed on top of the form. Keep your copy.

SUPPLEMENTAL TERM LIFE INSURANCE PLAN SUMMARY

When can I enroll?

- **New employees** may apply within 30 days of their employment date. Insurance will be effective the first day of the calendar month after we receive your application. Coverage amounts you elect within these 30 days are guaranteed, regardless of your medical history.
- **Participating employees** may elect additional coverage during annual open enrollment without providing proof of good health.
- **At any time** you may elect to participate in this benefit, or you may choose to increase your benefit beyond the amounts that are guaranteed (as identified above), by providing proof of good health. This applies to yourself and your family members. You can obtain an Evidence of Insurability form from your Human Resources, Payroll Office.

You may elect to purchase term life insurance for yourself, your spouse/domestic partner, and your dependent children under age 25. Your Supplemental Term Life insurance offers guaranteed coverage amounts for new employees, as well as guaranteed annual increase options for employees enrolled in the life insurance plan as of January 1 of that year.

Eligibility

Employees of the University of Wisconsin Hospital and Clinics who are eligible for state contribution to the State of Wisconsin group health insurance program may elect coverage under this plan. Retirees who are receiving a Wisconsin Retirement System benefit are not eligible.

If you have previously been employed at the University in a position that would have entitled you to enroll in this plan and you have not had a 30-day break in employment between positions, you are not entitled to enroll in this plan. Your option for enrollment is through Evidence of Insurability.

What members of your family are eligible?

Your lawful spouse who is not insured as an employee under the group policy is eligible. If you have filed an Affidavit of Domestic Partnership with your employer, your domestic partner who is not insured as an employee under the group policy is eligible. In addition, your children and your spouse's/domestic partner's children are eligible provided they are under age 25, are unmarried, and are dependent upon you for financial support. Only one employee-parent may cover the dependent children. If a child qualifies as an eligible employee, he or she is not eligible to be insured as a dependent child.

How much coverage can I apply for?

Employees may purchase insurance:	When you are hired:	Increases during annual open enrollment (effective May 1 of each year)	Increases at any other time (subject to evidence of insurability)
For yourself	\$5,000 increments to \$20,000	\$5,000, \$10,000 or \$20,000 (not to exceed total of \$200,000)	\$5,000 increments (not to exceed \$200,000)
For your spouse/ domestic partner	\$5,000 increments to \$10,000	\$5,000 or \$10,000 (not to exceed the amount you elect for yourself)	\$5,000 increments (not to exceed \$100,000 or 100% of employee coverage amount)
For your children	\$2,500 increments to \$5,000	\$2,500 (not to exceed the amount you elect for yourself)	\$2,500 (not to exceed \$10,000 or 100% of employee coverage amount)

How will I pay for this coverage?

Your premiums will be collected through convenient payroll deduction by the University of Wisconsin Hospital and Clinics. If you take a leave of absence, you may continue your insurance by paying your Human Resources Office **before** the first of the month during your leave. If you don't prepay during your leave, your coverage will end. You'll need to reapply within 30 days of your return to work, and your coverage levels will be limited to the levels available to a new employee.

**SUPPLEMENTAL TERM LIFE INSURANCE
 APPLICATION/CANCELLATION/CHANGE REQUEST**

SECTION I: EMPLOYEE INFORMATION

Name (last, first, middle initial)	Social Security number
Address (street, city, state, zip code)	Date of birth (mo/day/yr)
Employer name	Date employment began

SECTION II: ENROLLMENT OR CHANGE SECTION. Check the appropriate box(es) and complete the corresponding A-E in Section III as indicated.

- A. I elect to enroll for the life insurance coverage indicated below and meet the following eligibility requirements to enroll. Check all that apply:
- I am a new employee and meet all eligibility requirements explained on the instruction sheet of this form.
 - I was previously enrolled in the plan and let coverage lapse while on layoff or leave of absence. I am re-enrolling within 30 days of returning to work. Spouse/Domestic Partner and child coverage is available **ONLY** if spouse/domestic partner and child were covered before layoff or leave of absence.
- | | |
|-----------------------|---------------------|
| Date layoff/LOA began | Return to work date |
|-----------------------|---------------------|
- I was previously enrolled in the plan and have been rehired to an eligible position within 30 days since my previous appointment. **REHIRED ANNUITANTS ARE INELIGIBLE.**
 - I elect to enroll my spouse or domestic partner. Check one of the following:
 - I elect to enroll my spouse and am filing this application with my benefits coordinator within 30 days of the date of marriage. Date of marriage _____.
 - I elect to enroll my domestic partner and am filing this application with my benefits coordinator within 30 days of the date of filing my Affidavit for Domestic Partnership with my employer. Date of filing _____.
 - I elect to add child coverage since I have a child to cover for the first time due to birth, adoption, marriage or filing an Affidavit of Domestic Partnership with my employer. I am filing this application with my benefits coordinator within 30 days of the earliest applicable event.
- B. I elect to reduce life insurance coverage. I understand that spouse/domestic partner or child coverage amounts may not exceed my coverage amount. Employee coverage limits: \$5,000 to \$200,000, in increments of \$5,000. Spouse/Domestic Partner coverage limits: \$5,000 to \$100,000, in increments of \$5,000. Child coverage limits: \$2,500 to \$10,000, in increments of \$2,500.
- C. I elect to cancel the life insurance coverage indicated below. Cancellation of my coverage will automatically cancel my spouse/domestic partner and child coverage.
- D. I have legally changed my name to _____.

SECTION III: EMPLOYEE COVERAGE. Check ONLY the plans you are electing or canceling.

- A. I elect the following coverage amount. (Check **ONLY** one amount for employee, spouse/domestic partner and children.)
 Employee coverage \$5,000 \$10,000 \$20,000 Spouse/Domestic Partner coverage \$5,000 \$10,000
- | | |
|---------------------------------|--|
| Name of spouse/domestic partner | Spouse /domestic partner date of birth |
|---------------------------------|--|
- Child(ren) coverage \$2,500 \$5,000 (Amount selected covers each child in the family)
- | Name of Child | Child Date of Birth | Name of Child | Child Date of Birth |
|---------------|---------------------|---------------|---------------------|
| | | | |
| | | | |
- B. Reduce the following coverage (check one or more as appropriate)
 Employee coverage to \$ _____ Spouse/Domestic Partner coverage to \$ _____ Child coverage to \$ _____
- C. Check all that apply:
 Cancel Employee coverage (cancels all coverage) Cancel Spouse/Domestic Partner coverage Cancel Child coverage

I apply for the insurance coverage indicated above and assure all information provided is accurate. I have read the plan summary and agree to the rules and provisions. I hereby authorize the University of Wisconsin Hospital and Clinics to deduct the monthly premium from my earnings.

Signature X	Date (mo/day/yr)	Email address
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OFFICE USE ONLY	Affidavit of domestic partnership filed, if applicable <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Date rec'd by employer	Coverage effective date	Prem amt	Prem adj amt	Ded code	P/R mo