

UNIVERSITY OF WISCONSIN SYSTEM
Individual & Family Group Life Insurance (32871 – G)

Request to Initiate Disability Premium Waiver Claim
 (Form to be completed by UW Institution)

Eligibility Criteria for a Disability Premium Waiver

- Employee must have coverage in effect on begin date of disability
- Employee must be under age 60 on begin date of disability
- Employee must be considered totally and permanently disabled (a permanent disability is a total disability which has existed continuously for at least six months)

Instructions:

Complete and send this form to UW System Administration as soon as you know employee will be on a permanent or long term disability that is expected to last at least six months. Continue to collect premiums via Benefits Billing until you receive notification that Minnesota Life approved or denied the claim. ***Make a copy of this form your records.***

There is a six-month waiting period before the premium waiver is effective. The employee must pay premiums during this six-month waiting period. The six-month waiting period begins on the disability begin date. If the employee terminates employment during the six-month waiting period, the employee still must continue to pay the premium until the premium waiver is effective. If approved, the premium waiver will be effective on the first of the month following the completion of the six-month waiting period.

Employee Name		Social Security Number	Employee ID
Street Address		Telephone Number	
City, State, ZIP Code		Date of birth (MM/DD/CCYY)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
UW-Institution University of Wisconsin -			
Last Day Worked (MM/DD/CCYY)	Last Day for Which Paid (MM/DD/CCYY)	Last Month for Which Premium Has Been Collected Deduction Month/Year: Coverage Month/Year:	
Has employee terminated employment? <input type="checkbox"/> Yes (Date of termination: _____) <input type="checkbox"/> No If yes, is the termination due to an apparent disability? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the employee on a leave of absence (LOA)? <input type="checkbox"/> Yes (Date LOA commenced: _____) <input type="checkbox"/> No If yes, is the employee expected to return from LOA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Coverage Level In Effect on Disability Begin Date : Employee: Spouse/Domestic Partner: Children:	
Date (MM/DD/CCYY)	Signature of Employer Representative		Employer Telephone Number

Submit Form To:

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