

Individual and Family Group Term Life Insurance

You have an enrollment opportunity for life insurance coverage through the Individual and Family Group Life Insurance Plan if you meet all four of the following criteria:

1. You are working for the Universities of Wisconsin, and
2. You are eligible for coverage under the State of Wisconsin Group Health Insurance Program, and
3. Not collecting a Wisconsin Retirement System (WRS) benefit, and
4. You apply within 30 days of your first eligibility date.

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 (approval not guaranteed).

For an overview of the plan provisions, review the following:

<https://www.wisconsin.edu/ohrwd/benefits/download/life/if/fact.pdf> for the fact sheet

<https://www.wisconsin.edu/ohrwd/benefits/download/life/if/l&Fcert.pdf> for the certificate of insurance

You can contact your benefits office for printed materials. Retain a copy of the certificate for your records.

Plan summary

The plan offers term life insurance for employees, an employee's spouse or domestic partner and eligible dependent children. The following is a summary of the life insurance coverage available through the plan.

Coverage Options for New Employees

When **first eligible** for coverage as a new employee or newly benefits-eligible employee, you may select coverage of \$5,000; \$10,000; \$15,000 or \$20,000 on yourself, \$5,000 or \$10,000 on your spouse or domestic partner and \$2,500 or \$5,000 on your children. If you enroll in child coverage, all eligible children are automatically covered.

Opportunities to Increase Coverage Levels

Each year there is an **annual opportunity to increase your coverage levels**. You may increase employee coverage by \$5,000; \$10,000; \$15,000 or \$20,000, spouse or domestic partner coverage by \$5,000 or \$10,000 and child coverage by \$2,500 per year.

You may also increase your coverage levels by applying for additional coverage through Evidence of Insurability (approval not guaranteed).

Maximum Coverage Levels

- Maximum Employee Coverage: \$300,000
- Maximum Spouse or Domestic Partner Coverage: \$150,000*
- Maximum Child Coverage: \$25,000*

*Spouse or Domestic Partner and/or Child coverage cannot exceed the employee level of coverage.

Universities of Wisconsin Employees Married to or in a Domestic Partnership with another Universities of Wisconsin Employee

You may not be covered under this plan as both an employee and a spouse or domestic partner on another Universities of Wisconsin employee's coverage. This rule also applies to child coverage - you cannot be covered as both an employee and a child on your parent's coverage, or if both parents are Universities of Wisconsin employees, only one parent can carry child coverage.

Effective Date of Coverage

To enroll in coverage as a new employee or newly benefits-eligible employee, you must submit an application within 30 days of first becoming eligible for coverage. This is typically your first day of work, provided you meet the four eligibility requirements listed above. Coverage is effective the first of the month following receipt of the application by your Universities of Wisconsin institution human resources office.

Conversion Rights

At termination or loss of eligibility under the group plan, you may convert your coverage to an individual life insurance policy. You may convert coverage by applying for an individual policy and paying the first premium within 31 days after your group insurance terminates. No evidence of insurability will be required.

Individual and Family Group Term Life Insurance - Application/Cancellation/Change Form Instructions

INSTRUCTIONS FOR COMPLETING APPLICATION

Section 1: Applicant Information

Print/type all requested information legibly in the space provided. Missing information may delay enrollment processing.

Section 2: Enrollment in Coverage

Enrollment: Select this option to enroll if you are newly hired or newly eligible for this life insurance. Check the box(es) next to all coverage types and levels for which you wish to enroll.

Enroll a spouse or domestic partner: Select this option if you are currently insured and want to add a spouse or domestic partner to your coverage. Enter the date of marriage or the date you established a domestic partnership for benefit purposes. You must submit an application to add coverage within 30 days of the date of marriage or domestic partnership effective date.

Enroll a child(ren): Select this option if you are currently insured and want to add a child(ren) to your coverage. Enter the date that you had a child to cover for the first time (date of birth, date of adoption, date of marriage/domestic partnership if spouse or domestic partner has eligible children as of the date of marriage/domestic partnership). You must submit an application to add coverage within 30 days of the date that you have a child to cover for the **FIRST** time. Once you have child coverage in effect, all subsequent eligible children are automatically covered and you do not need to submit an application to add additional children.

Section 3: Cancel Coverage

Enter the reason that you would like to cancel coverage and enter the date of any applicable qualifying event. Check the box(es) next to all coverage levels that you would like to cancel. If you cancel employee coverage, all coverage will be canceled. If you cancel child coverage, coverage will end for all covered children.

Section 4: Reduce Coverage Level

Check the box(es) next to all coverage levels that you would like to reduce and enter the amount of coverage that you would like to carry under all applicable coverage types. Coverage amounts for your spouse, domestic partner or child cannot exceed the coverage you have on yourself.

Section 5: Reinstate Coverage

Reinstate coverage - Return from a Leave of Absence: Select this option if you allowed your coverage to lapse during a leave of absence and would like to reinstate the same level of coverage that you carried prior to your leave of absence. Enter your last day worked and return to work dates. You must submit your application within 30 days of your return to work date.

Reinstate coverage - Returning Academic Year or Seasonal Employee: Select this option if you have a continuing academic year or seasonal appointment and your coverage lapsed during a break in employment between academic years or during a seasonal break in employment. You may reinstate the same level of coverage that you carried prior to your work break. Enter your last day worked and return to work dates. You must submit your application within 30 days of your return to work date.

Section 6: Transfer Coverage (due to a qualifying event)

Select one of these two options to transfer the level of coverage that you had as a spouse or domestic partner under another Universities of Wisconsin employee's coverage to your own employee coverage. You can only transfer the level of coverage that you had as a covered spouse or domestic partner. Enter the amount of coverage that you would like to transfer in the last line of the section (limits apply). **All elections must be made within 31 days of the qualifying event** and are effective on the first of the month on or after the remaining employee's benefits office receives the completed application. Restrictions may apply so contact your institution's benefits office for additional information.

Transfer to employee coverage due to a termination, retirement, loss of eligibility or death of the covered employee: Select this option if you are currently covered as a spouse or domestic partner on another Universities of Wisconsin employee's coverage who is terminating employment, has lost eligibility for coverage or has died and you would like to transfer coverage to yourself as an active employee. If you are transferring coverage due to termination or loss of eligibility, you may also transfer the amount of coverage your spouse or domestic partner carried as an employee to spouse or domestic partner coverage under your plan. The maximum coverage transferable is the lesser of the amount the insured spouse or domestic partner carried as an active employee, the amount that the remaining employee carries as employee coverage or \$150,000. Any amount that cannot be transferred can be converted to an individual policy. Child coverage will automatically transfer to you, the remaining insured employee.

Transfer to employee coverage due to a divorce/end of domestic partnership: Select this option if you are covered as a spouse or domestic partner on your former spouse or domestic partner's policy and are now enrolling in coverage as the employee. A child may only be covered under one parent's plan.

Section 7: Signature - Sign and date the application. Submit the completed application to your Universities of Wisconsin institution human resources office.

**Individual and Family Group Term Life Insurance
Application/Cancellation/Change Request (Policy 32871-G)**

Return to your Universities of Wisconsin institution human resource office.

Section 1: Applicant Information

Applicant name (last, first, middle, previous)		Spouse/domestic partner name (last, first, middle, previous)	
Street address (street, city, state, zip code)		Employee identification number	
Daytime phone number	Date of birth (mo/day/yr)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number

Section 2: Enrollment in Coverage

New Enrollment
I want to enroll for the life insurance coverage as indicated:

<input type="checkbox"/> Employee	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000
<input type="checkbox"/> Spouse/Domestic Partner:	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000		
<input type="checkbox"/> Child(ren):	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000		

Enroll a spouse or domestic partner (due to a marriage or establishment of a domestic partnership):
Date of marriage/begin date of domestic partnership: ____/____/____ **Coverage cannot exceed employee coverage**
I elect the following coverage for my spouse/domestic partner: \$5,000 \$10,000

Enroll a child(ren) (due to birth, adoption, marriage or establishment of a domestic partnership for benefit purposes):
Date of event: ____/____/____ **Coverage cannot exceed employee coverage**
I elect the following coverage for my child(ren): \$2,500 \$5,000

Section 3: Cancel Coverage

Cancellation: I want to voluntarily cancel the life insurance coverage listed below.
Reason: _____ **Event date:** ____/____/____

I cancel the following coverage:

Employee (cancels all coverage) Spouse/Domestic Partner Child(ren) (cancels all child coverage)

Section 4: Reduce Coverage Level

Reduce Life Insurance: I elect to reduce the following coverage levels:

<input type="checkbox"/> Employee coverage to \$ _____	<input type="checkbox"/> Spouse/Domestic Partner coverage to \$ _____	<input type="checkbox"/> Child(ren) coverage to \$ _____
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Section 5: Reinstate Coverage

Reinstate coverage - Return from a leave of absence: I am reapplying for the same level of coverage that lapsed while on an unpaid leave of absence (LOA).

Reinstate coverage - Returning academic year, seasonal employee or military leave: I am reapplying for the same level of coverage that lapsed while I was on an academic year or seasonal break or military leave.

Please fill in both dates: Last day worked: ____/____/____ Return to work: ____/____/____

Section 6: Transfer Coverage due to a Qualifying Event

Transfer to employee coverage due to a termination, retirement, loss of eligibility or death of the covered employee.
I am currently covered as a spouse or domestic partner on another Universities of Wisconsin employee's coverage who is no longer eligible to carry coverage as an active employee and would like to transfer employee coverage to myself.
Enter amount below.
Name of Spouse or Domestic Partner: _____ Termination/retirement date: ____/____/____

Transfer to employee coverage due to a divorce/end of domestic partnership. I was covered as a spouse or domestic partner on my former spouse's or domestic partner's policy and I elect to enroll in coverage as the employee.
Enter amount below.
Name of former Spouse or Domestic Partner: _____ Divorce/Domestic Partnership end date: ____/____/____

Enter the amount of coverage to transfer:
 Employee \$ _____ Spouse or Domestic Partner \$ _____ Child(ren) \$ _____

Section 7: Signature - sign here and return completed application to your employer

I understand that Wis. Stats §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. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary.

Applicant signature X	Date (mo/day/yr)
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FOR OFFICE USE ONLY

Date received by employer	Received by	Hire/event date	Coverage effective date
Affidavit of domestic partnership on file (if applicable) <input type="checkbox"/> UW System Affidavit		Premium \$	Processor initials Employee ID

Copy and distribute: eBenefits File Employee