Individual & Family Life Insurance (Policy #32871-G)
Annual Option to Increase Life Insurance Coverage Form

The Annual Increase Option (AIO) period (*September 25 – October 20, 2023*) is your opportunity to increase your Individual & Family Life Insurance coverage.

You must have coverage in force under this plan to participate in the Annual Increase Option period. To increase your coverage, complete and **return this form to your institution benefits contact by 4:30 pm on October 20, 2023. No action is required** to maintain your current coverage level(s).

Current Coverage Level: You can review your current coverage level in the MyUW Portal: my.wisconsin.edu (go to the Benefit Information Module, scroll to the bottom of the page and select "View Benefits Summary Detail").

Coverage may be increased by the following amounts:

- **Employee:** $5,000, $10,000, $15,000 or $20,000 (Maximum coverage level: **$300,000**)
- **Spouse or Domestic Partner:** $5,000 or $10,000 (Maximum coverage level: **$150,000**)
- **Child(ren)**: $2,500 (Maximum coverage level: **$25,000**)

Your spouse / domestic partner or child coverage cannot exceed your level of employee coverage.

The increased coverage level is effective January 1, 2024 (new premium deducted from December earnings).

Insured Employee Information:

Insured Employee Name (last, first, middle)	Spouse/Domestic Partner Name (last, first, middle)
Daytime Telephone Number	Employee ID (8 digits)

Elect Coverage Level Increase (choose one under each coverage level, if applicable):

*I want to **increase** my coverage by the following amount(s):*	☐ **Employee Coverage Level:**	☐ $5,000	☐ $10,000	☐ $15,000	☐ $20,000
	☐ **Spouse/Domestic Partner Coverage Level:**	☐ $5,000	☐ $10,000		
	☐ **Child(ren) Coverage Level:**	☐ $2,500			

Signature (*Sign here and return completed application to your institution benefits contact):*

I have read the above information and elect to increase my life insurance coverage amount(s) per the amounts checked above. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary.

Employee Signature	Date (mo/day/yr)

Additional Information:

- Individual & Family Life Insurance Plan information, premiums and forms: www.wisconsin.edu/ohrwd/benefits/life/if/
- Certificate of Insurance: www.wisconsin.edu/ohrwd/benefits/download/life/if/I&Fcert.pdf
- 2024 Individual & Family Life Insurance Premium Calculator: uwservice.wisconsin.edu/indfam-increase-calculator/
- To **decrease or cancel coverage**, submit a paper application (www.wisconsin.edu/ohrwd/benefits/download/life/if/app.pdf) to your institution benefits contact at any time.

For Office Use Only					
Date Received:	Received by:	Processor Initials:	Coverage effective date: **1/1/2024**	Employee ID:	
Current & New Coverage Levels *(effective 1/1/2024)*					
2023 Coverage Amount	**2024 Coverage Amount (NEW)**	**2023 Coverage Amount**	**2024 Coverage Amount (NEW)**	**2023 Coverage Amount**	**2024 Coverage Amount (NEW)**
Employee: **$**	**$**	Sp/DP: **$**	**$**	Child: **$**	**$**

COPY AND DISTRIBUTE: ☐ eBenefits File ☐ Employee

RETURN TO YOUR INSTITUTION BENEFITS CONTACT