



**University of Wisconsin System  
Accidental Death and Dismemberment Insurance  
Zurich American Insurance Company  
Policy GTU 8364005**



You can enroll in coverage under the AD&D plan at any time provided you meet the following criteria:

1. You are working for the University of Wisconsin System, and
2. You are eligible for coverage under the State of Wisconsin Group Health Insurance Program, and
3. You are not collecting a Wisconsin Retirement System benefit.

For an overview of plan provisions, please review the AD&D fact sheet at: <https://www.wisconsin.edu/ohrwd/benefits/download/life/add/fact.pdf> or the certificate of insurance at: <https://www.wisconsin.edu/ohrwd/benefits/download/life/add/cert.pdf> for comprehensive program information. You can contact your benefits office for printed materials. Retain a copy of the certificate for your records.

### **Plan Summary**

The Accidental Death and Dismemberment Insurance plan is sponsored by the Board of Regents of the University of Wisconsin System. This plan offers accidental death and dismemberment insurance, as well as the Zurich Travel Assist plan to employees, an employee's spouse/domestic partner and eligible dependent children.

#### **Enrollment and Effective Date of Coverage**

New employees may enroll within 30 days of employment. Coverage is effective the first of the month following 30 days from your date of hire or WRS eligibility event date.

Eligible employees may enroll in, change or cancel coverage at any time. Coverage is effective on the first of the month on or following receipt of the application by your UW institution's benefits office.

#### **Coverage Level Options**

You may select employee or family coverage. Family coverage includes your spouse or domestic partner and eligible children. You may select a benefit amount from \$25,000 to \$500,000. Covered family members will be insured for a percentage of the benefit amount you select. See the AD&D fact sheet for details.

#### **Accidental Death and Dismemberment Coverage**

If you or a covered family member have a covered accident that results in a loss of life, loss of limb(s), sight, speech, hearing, loss of use of certain limbs and/or permanent and total disability, benefits may be payable under this plan.

#### **Zurich Travel Assist**

Coverage under this plan includes Zurich Travel Assist coverage at no extra cost. Zurich Travel Assist is a comprehensive travel assistance program that provides you benefits when you travel 100 or more miles from your residence.

#### **UW System Employees Married to or in a Domestic Partnership with another UW System Employee**

You may be covered under this plan as either an employee or as a spouse or domestic partner on another UW System employee's coverage – not both. If both UW System employees are covered as an employee, only one may select a family plan that covers their mutually eligible children.

#### **Conversion and Continuation Rights**

At termination or loss of eligibility under the group plan, you may convert your coverage to a non-group plan within 60 days of the coverage end date. If you terminate coverage due to retirement, you may continue group coverage at the same rate by submitting a Continuation Form (UWS 1249) within 60 days of the coverage end date.

### **Instructions for Completing the Application**

#### **Section 1: Applicant Information**

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

#### **Section 2: Premium and Benefit Amounts**

Review the benefit amounts and associated monthly premiums to determine what level of coverage you would like to select.

#### **Section 3: Reason for Submitting Application**

**New Enrollment:** Check this box if you do not currently carry coverage and would like to enroll.

**Cancellation of Coverage:** Check this box to cancel your current coverage.

**Change Coverage Level or Benefit Amount:** Check this box to change from single to family coverage or family to single coverage and/or change your benefit amount.

#### **Section 4: Select Coverage Level and Benefit Amount**

Select Employee Only Coverage if you would like to cover only yourself. Select Family Plan Coverage if you would like to cover yourself and all eligible family members. Enter your selected Benefit Amount (one of the amounts listed in Section 2).

#### **Section 5: Signature**

Sign and date the application. Submit the completed application to your UW institution's benefits office.



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**Section 1: Applicant Information**

Applicant Name (Last, First, Middle)		Social Security Number
Address (Street, City, State, Zip Code)		
UW Institution Name	Date of Birth (Mo/Day/Yr)	

**Section 2: Premium and Benefit Amounts**

An employee may select Employee Only or Family coverage. Below are the benefit amounts available and the associated monthly premium.

Benefit Amount	\$25,000	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Employee Only Premium	\$.65	\$1.30	\$2.60	\$3.90	\$5.20	\$6.50
Family Plan Premium	\$.98	\$1.95	\$3.90	\$5.85	\$7.80	\$9.75
Benefit Amount	\$300,000	\$350,000	\$400,000	\$450,000	\$500,000	
Employee Only Premium	\$7.80	\$9.10	\$10.40	\$11.70	\$13.00	
Family Plan Premium	\$11.70	\$13.65	\$15.60	\$17.55	\$19.50	

**Section 3: Reason for Submitting Application**

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Cancellation of Coverage
<input type="checkbox"/> Change Coverage Level or Benefit Amount	

**Section 4: Select Coverage Level and Benefit Amount**

<b>Enrollment:</b> I want to enroll for the life insurance coverage level indicated below:	
<input type="checkbox"/> Employee Only Coverage	<b>Enter Benefit Amount Selected: \$</b>
<input type="checkbox"/> Family Plan Coverage*	<b>Enter Benefit Amount Selected: \$</b>

\*If you would like to cover a domestic partner or partner's children under the family plan, you must first establish a domestic partnership for employee benefit purposes. See [www.uwsa.edu/ohrwd/benefits/dp/](http://www.uwsa.edu/ohrwd/benefits/dp/) for more information.

**Section 5: Signature (sign here and return completed application to your Institution Payroll or Benefits Office)**

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 deductions of the monthly premium from my salary.	
Date (Mo/Day/Yr)	Employee signature

**Beneficiary Designation** available online at [www.uwsa.edu/ohrwd/benefits/life/add/bendes.pdf](http://www.uwsa.edu/ohrwd/benefits/life/add/bendes.pdf).

**Access** and print your Zurich Travel Assist ID Card at [www.uwsa.edu/ohrwd/benefits/life/add/zurichcard.pdf](http://www.uwsa.edu/ohrwd/benefits/life/add/zurichcard.pdf).

**For Office Use Only:**

Date Received by Employer (Mo/Day/Yr)	Received By	Hire Date (Mo/Day/Yr)	Coverage Effective Date	Premium	Processor Initials	Person ID
				\$		

Has employee established a UWS or ETF domestic partnership?  No  Yes If Yes, Effective Date: