University of Wisconsin System
Human Resources & Workforce Diversity
780 Regent Street, Suite 224
Madison, WI 53715

Minnesota Life
400 Robert Street North
St. Paul, MN 55101-2098
Policy 32871-G

Individual and Family Group Term Life Insurance

You can enroll in the Individual and Family Group Life Insurance Plan if you meet all four of 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. Not collecting a Wisconsin Retirement System 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, see the plan brochure at https://www.wisconsin.edu/ohrwd/benefits/download/life/if/broch.pdf or the certificate of insurance https://www.wisconsin.edu/ohrwd/benefits/download/life/if/cert.pdf. You can contact your benefits office for printed materials. Retain a copy of the certificate for your records.

Plan Summary

The Individual and Family Group Life Insurance plan is sponsored by the Board of Regents of the University of Wisconsin System. 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/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/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/Domestic Partner Coverage: $150,000 *
Maximum Child Coverage: $25,000 *

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

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

You may not be covered under this plan as both an employee and a spouse or domestic partner on another UW System 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 UW employee's 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 30 days from your date of hire or WRS eligibility event date.

Conversion Rights

At termination or loss of eligibility under the group plan, you may convert your coverage to a new 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 2: Enrollment in Coverage

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

Enroll a child(ren): Select this option if you are currently insured and want to add a child(ren) to 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/domestic partner has eligible children as of the date of marriage). 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, Seasonal Employee or Military Leave: Select this option if you have a continuing academic year or seasonal appointment, or are returning from a military leave and your coverage lapsed during this 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 UW 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 provided 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 UW System 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/domestic partner carried as an employee to spouse/domestic partner coverage under your plan. The maximum coverage transferrable 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. Any child coverage in effect at the time of transfer will automatically transfer 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
Print, sign and date the application. Submit the completed application to your UW institution's benefits office.

Return to Your UW Institution's Benefits Office

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

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 Telephone Number	Date of Birth (mo/day/yr)	Gender ☐ Male ☐ Female / Social Security number

Section 2: Enrollment in Coverage

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

- ☐ **Employee Coverage:** ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000
- ☐ **Spouse/Domestic Partner Coverage:** ☐ $5,000 ☐ $10,000
- ☐ **Child(ren) Coverage:** ☐ $2,500 ☐ $5,000

Spouse/domestic partner and child coverage cannot exceed Employee coverage

☐ **Enroll a spouse/domestic partner (Due to marriage or establishment of a domestic partnership):**
Date of Marriage/Begin Date of Domestic Partnership: _____
I elect the following coverage for my **spouse/domestic partner**: ☐ $5,000 ☐ $10,000

☐ **Enroll a child(ren) (Due to a birth, adoption, marriage or establishment of a domestic partnership for benefit purposes):**
Date of event: _____
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 elect to 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 level(s):

☐ Employee Coverage to: $ _____
☐ Spouse/Domestic Partner Coverage to: $ _____
☐ Child(ren) Coverage to: $ _____

Section 5: Reinstate Coverage

	Please fill in both dates:	
☐ **Reinstate Coverage – Return from a Leave of Absence:** I am reapplying for same level of coverage that lapsed while on an unpaid leave of absence (LOA).	Last day worked:	Return to work date:
☐ **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, seasonal break or military leave.	(mm/dd/ccyy)	(mm/dd/ccyy)

Section 6: Transfer Coverage due 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/domestic partner on another UW System employee's coverage who is no longer eligible to carry coverage as an active employee and would like to transfer employee coverage to myself.
Name of Spouse/Domestic Partner: _____
Termination/Retirement Date: _____

☐ **Transfer to employee coverage due to a divorce/end of domestic partnership:** I was covered as a spouse/domestic partner on my former spouse's/domestic partner's policy and I elect to enroll in coverage as the employee.
Name of Former Spouse/Domestic Partner: _____
Divorce/Domestic Partnership End Date: _____

Enter the amount of coverage to transfer:
☐ Employee $ _____
☐ Spouse/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 herby 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	Date (mm/dd/ccyy)

For Office Use Only

Date received by employer	Received by	Hire/Event date	Coverage effective date

Affidavit of Domestic Partnership on file (if applicable): ☐ ETF Affidavit ☐ UWS Affidavit ☐ N/A	Premium: $	Processor Initials:	Empl ID

COPY AND DISTRIBUTE: ☐ UWSA ☐ UW Institution ☐ Employee