WISCONSIN PUBLIC EMPLOYERS GROUP LIFE INSURANCE PROGRAM
INSTRUCTIONS FOR COMPLETION OF EVIDENCE OF INSURABILITY APPLICATION

Group Life Insurance
§40.70 (6)

Employees who did not enroll during their initial enrollment period, or insured employees who wish to apply for more insurance for themselves or their spouse/domestic partner or dependents, may apply using this Evidence of Insurability form. This application must be received by Minnesota Life Insurance Company (MLIC) during the employee's active employment and prior to the date the applicant reaches age 70. Active employees who are turning age 70 and do not have Additional coverage, or new employees age 70 or over may apply for Additional coverage using this form. Employees age 70 or over do not need to have Basic coverage to apply for Additional coverage.

EMPLOYER:

1. Review the eligibility criteria outlined in the *Life Insurance Employer Administration Manual* (ET-1117), and the cover sheet of this application.
2. Determine the plan(s) for which the employee may enroll.
3. Complete the Employer Information section of the application.
4. Instruct the employee to complete the form and to make a photocopy for his or her records BEFORE submitting to MLIC.
5. MLIC will send you a written notice regarding the final outcome of this application.

EMPLOYEE:

1. Your employer must complete the Employer Information section of this application.
2. Review the Plan Booklet (ET-2101) and the cover sheet of this application for information about the plans you wish to apply for.
3. Complete both sides of the application.
4. If you are applying for insurance for yourself:
   a) complete the boxes for the employee's height, weight, date of birth and gender.
   b) answer the health questions using the "Employee" check boxes.
5. If you are applying for insurance for your spouse/domestic partner:
   a) complete the boxes for your spouse/domestic partner's height, weight, date of birth and gender.
   b) answer the health questions using the "Spouse/Domestic Partner" check boxes.
6. If you are applying for insurance for your dependent children, answer the health questions using the check boxes for "Dependent Children."
   - If you have more than one dependent child, answer "Yes" if the question can be answered "Yes" for any of your dependent children. If the answer to the question is "No" for all your dependent children, then check "No."
   - On the reverse side of the form, list your children under the section entitled "Complete For Dependent Child(ren) Coverage."
7. If your answer is "Yes" to any of the health questions, please provide details by completing the Health Information section on the reverse side of the form. Applicants are responsible for the cost of medical examination(s), if required.
8. To obtain Spouse and Dependent coverage, your spouse/domestic partner and all eligible dependent children must be included on the form.
9. Sign and date the form at the bottom of the front side. Your spouse/domestic partner must also sign the form if applying for Spouse and Dependent Coverage.
10. Make a photocopy of the completed form for your records.
11. Mail the original completed form directly to:

    Minnesota Life Insurance Company
    P.O. Box 259708
    Madison, WI 53725-9708

This application must be received by MLIC no later than 90 days from the date signed to ensure medical information is current.

You and your employer will receive a report of action after insurability has been determined.

WISCONSIN PUBLIC EMPLOYERS GROUP LIFE INSURANCE PROGRAM
Plan Summary

The Wisconsin Public Employers (WPE) Group Life Insurance program offers employee coverage of up to five times your annual earnings. All five levels of insurance are available to state employees. The amount of coverage available to local government employees depends on which plans are offered by your employer. The following is a summary of the life insurance coverage that is available.

Coverage Options

The **Basic Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000. Your employer is required to contribute to the cost of this insurance.

The **Supplemental Plan** provides coverage equal to your earnings for the previous year, rounded up to the next $1,000. The state contributes to the cost of this coverage for state employees. Local government employers are not required to contribute.

The **Additional Plan** provides up to three units of coverage. Each unit of coverage equals your earnings for the previous year, rounded up to the next $1,000. Depending on how many levels of coverage are offered by your employer, you may choose 1, 2, or 3 units of Additional coverage. Employer contributions are not required.

The **Spouse & Dependent Plan** provides coverage for your spouse/domestic partner and all dependent(s). If you elect one unit of coverage, your spouse/domestic partner will have $10,000 in coverage and each dependent (regardless of the number) will have $5,000 in coverage. If you elect two units, your spouse/domestic partner will have $20,000 in coverage and each dependent will have $10,000 in coverage.

Amount of Coverage

The following is an example of how the amount of employee coverage is determined for an employee who chooses Basic, Supplemental and 3 Units of Additional coverage. The employee's previous year earnings are $33,200. The earnings rounded up to the next thousand equals $34,000 of coverage. The employee has coverage as follows:

Basic: (1x earnings) = $34,000
Supplemental: (1x earnings) = $34,000
Additional (3 units): (3x earnings) = $102,000
Total Amount of Insurance Coverage: (5x earnings) = $170,000

Coverage for Active Employees Age 70 and Over

If you are actively employed when you turn age 70, your Basic coverage will reduce to the final post-retirement coverage amount and continue for life with no premiums due. Your Supplemental and Spouse & Dependent coverage will cease on your 70th birthday. Your Additional coverage will continue until you cancel coverage or terminate employment.

Effective Date of Coverage

The effective date for coverage approved under Evidence of Insurability is the first of the month following the date the application is approved by Minnesota Life Insurance Company.

Evidence of Insurability Application
Wisconsin Public Employers Group Life Insurance Program
Wis. Stats §40.70(6)
Minnesota Life Insurance Company - A Securian Company
P.O. Box 259708 ● Madison, WI 53725-9708

MINNESOTA LIFE

EMPLOYEE INFORMATION

Last name	First name	Middle initial	Social Security number	Date of birth

Street address	City	State	Zip code

EMPLOYER INFORMATION - To be completed by employer.

Current employer (or state agency)	Employer identification number	Unit number
	69 - 036 -	

Date of hire at current employer	WRS annual earnings	☐ Actual ☐ Estimated	Amount of basic insurance (if insured)

INSURANCE DESIRED - Check only the plans you are applying for. Basic insurance is a prerequisite to all coverages except for employees age 70 or over selecting Additional coverage.

☐ **Basic Plan** (1x earnings)

☐ **Supplemental Plan** (1x earnings)

Spouse & Dependent Plan
(check only one box below)
☐ 1 Unit (Spouse/Domestic partner = $10,000; Dependent = $5,000)
☐ 2 Units (Spouse/Domestic partner = $20,000; Dependent = $10,000)

Additional Plan
(check only one box below)
☐ 1 Unit (1x earnings)
☐ 2 Units (2x earnings)
☐ 3 Units (3x earnings)

SIGNATURE - Please read and sign below.

Upon approval of this application, I hereby authorize payroll deduction from my earnings. I authorize any physician, medical practitioner, hospital, clinic or other health care provider, insurance company, or employer who has any records or knowledge of me or my physical or mental health, or that of my dependent children, to give such information and any other nonmedical information to Minnesota Life Insurance Company ("Company") or its authorized representative. This shall include information as to my medical history, consultations, diagnosis, prescriptions or treatment, tests, and information as to alcohol, drug abuse or sickle cell disease.

The answers provided on this application are representations of each person signing below. The answers given are true and complete. It is understood that Minnesota Life Insurance Company, (the Company), St. Paul, Minnesota 55101-2098 shall incur no liability because of this application unless and until it is approved by the Company and the first premium is paid while my health and other conditions affecting my insurability are as described in this application. I understand that false or incorrect answers to the above questions may lead to rescission of coverage. If coverage is rescinded, an otherwise valid claim will be denied.

Employee signature	Daytime telephone number	Date signed
X	( )	

Spouse/domestic partner signature (Required if applying for Spouse and Dependent Insurance)
X

Print spouse/domestic partner name

Is your spouse/domestic partner also applying separately as an employee for coverage under this program?	☐ Yes ☐ No	Daytime telephone number	Date signed
		( )	

PROVIDE ADDITIONAL HEALTH INFORMATION ON REVERSE SIDE

F54666 Rev 3-2010

ET-2305 (Rev 3/2010)

Employee name	Social Security number

HEALTH INFORMATION - Provide the following information only for those that apply.

EMPLOYEE				SPOUSE/DOMESTIC PARTNER			
Height	Weight	Date of birth	Gender ☐ M ☐ F	Height	Weight	Date of birth	Gender ☐ M ☐ F

If you are applying for the Spouse & Dependent Plan, your spouse/domestic partner and all eligible dependents must be listed on your application. Check one:

☐ I have a spouse/domestic partner and dependent children.
☐ I currently have no spouse/domestic partner, but I do have eligible dependents.
☐ I currently have no eligible dependents, but I do have a spouse/domestic partner.

Please answer the following health questions for all applicants. If your answer to questions 1, 2 or 3 below is "yes", provide details including dates, names and addresses of doctors or hospitals, the reason for the visit or consultation, the diagnosis, and the treatment under Additional Health Information section below.

EMPLOYEE		SPOUSE/ DOMESTIC PARTNER		DEPENDENT CHILDREN		HEALTH QUESTIONS
YES	NO	YES	NO	YES	NO	
☐	☐	☐	☐	☐	☐	1. During the past three years, have you for any reason consulted a physician(s) or other health care provider(s), or been hospitalized?
☐	☐	☐	☐	☐	☐	2. Have you ever had, or been treated for, any of the following: heart, lung, kidney, liver, nervous system, or mental disorder; high blood pressure; stroke; diabetes; cancer or tumor; drug or alcohol abuse including addiction?
☐	☐	☐	☐	☐	☐	3. Have you been diagnosed by a member of the medical profession as having AIDS or ARC?

ADDITIONAL HEALTH INFORMATION - Specify by name if information is for employee, spouse/domestic partner or dependent.

NAME	RELATIONSHIP TO EMPLOYEE (self, spouse/domestic partner, dependent)	DATE	NAME AND ADDRESS OF DOCTOR, CLINIC, HOSPITAL	REASON FOR CONSULTATION	DIAGNOSIS AND TREATMENT

COMPLETE FOR DEPENDENT CHILD(REN) COVERAGE - List Oldest to Youngest

CHILD'S NAME	CHILD'S BIRTHDATE	GENDER	CHILD'S NAME	CHILD'S BIRTHDATE	GENDER

REPORT OF ACTION - For Insurance Company Use

Basic: _____ ☐ Appr'd ☐ Decl. ☐ Decl. incom. By _____	Supplemental: _____ ☐ Appr'd ☐ Decl. ☐ Decl. incom. By _____	Total amount of insurance: Employee: _____
Additional: _____ ☐ Appr'd ☐ Decl. ☐ Decl. incom. By _____	Spouse/domestic partner & Dependent: ☐ 1 Unit ☐ 2 Units ☐ Appr'd ☐ Decl. ☐ Decl. incom. By _____	Spouse/domestic partner and/or dependents: _____